

**INDIANA POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
AND APPOINTMENT OF HEALTH CARE REPRESENTATIVE**

INSTRUCTIONS

PRINT YOUR NAME
AND ADDRESS

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF YOUR
ATTORNEY-IN-FACT

SIGN YOUR INITIALS
NEXT TO THE
POWERS YOU GIVE TO
YOUR ATTORNEY-IN-
FACT

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF YOUR
BACK-UP
ATTORNEY-IN-FACT

PRINT THE DATE
SIGN AND PRINT
YOUR NAME IN FRONT
OF AN ADULT
WITNESS AND A
NOTARY
HAVE AN ADULT
WITNESS SIGN (WITH
A NOTARY) AND
PRINT THEIR NAME
AND PRINT THE DATE

I, _____
(name)
of _____
(address)
hereby appoint _____
(name of attorney-in-fact)

(address)

(home telephone number) (work telephone number)

as my attorney-in-fact to make health care decisions on my behalf whenever I am incapable of making my own health care decisions.

I. I grant my attorney-in-fact the following powers in matters affecting my health care:

- _____ (1) to employ or contract with servants, companions, or health care providers involved in my health care;
- _____ (2) to consent to or refuse any health care, treatment, service or procedure to maintain, diagnose, treat or not to treat my physical or mental conditions;
- _____ (3) to consent to my admission or release me from a hospital or health care facility;
- _____ (4) to have access to my records, including medical records; concerning my condition;
- _____ (5) to make anatomical gifts on my behalf;
- _____ (6) to request an autopsy; and
- _____ (7) to make plans for the disposition of my body.

II. In the event the person I appoint above is unable, unwilling or unavailable to act as my attorney-in-fact, I hereby appoint:

(name of successor attorney-in-fact)
of _____

(address)

(home telephone number) (work telephone number)
as my successor attorney-in-fact.

Executed this _____ day of _____, 20_____.

Signed: _____

Printed Name: _____

Witness Signature (an adult other than the Health Care Representative):

Printed name of Witness: _____

Date: _____

APPOINTMENT OF MY ATTORNEY-IN-FACT AS MY HEALTH CARE REPRESENTATIVE; DECISIONS REGARDING WITHDRAWING OR WITHHOLDING HEALTH CARE

INSTRUCTIONS

THESE DOCUMENTS MUST BE NOTARIZED—TAKE THESE DOCUMENTS TO A NOTARY PUBLIC AND MAKE SURE YOU AND YOUR ADULT WITNESS SIGN THESE DOCUMENTS IN THE PRESENCE OF THE NOTARY

PRINT THE DATE SIGN AND PRINT YOUR NAME IN FRONT OF AN ADULT WITNESS AND A NOTARY PUBLIC

HAVE AN ADULT WITNESS SIGN (WITH A NOTARY) AND PRINT THEIR NAME AND PRINT THE DATE

In addition to the powers granted above, I appoint my attorney-in-fact as my **health care representative**, and authorize my attorney-in-fact and health care representative to make decisions in my best interest concerning the consent, withdrawal or withholding of health care. I understand health care to include any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well-being.

Health care also includes the providing of nutrition and hydration through intravenous, gastrostomy or nasogastric tubes. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

The authority granted herein shall become effective when my attending physician determines that I am incapable of consent and is not effective while I am capable of consent.

I hereby designate my Health Care Representative as my personal representative with respect to all medical information, including protected health information as defined and governed by the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations thereunder. This provision of this Appointment of Health Care Representative is effective upon execution and is not affected by subsequent incapacity.

If my Health Care Representative resigns or is unwilling to comply with this written appointment, such Health Care Representative may not exercise further power under this appointment and shall so inform me or my legal representative, if unknown, and my health care provider, if known.

I reserve the right to revoke this Appointment at any time by oral or written notice to my Health Care Representative and to revoke the authority granted to my Health Care Representative by oral or written notice to my health care provider.

Executed this _____ day of _____, 20_____.

Signed: _____

Printed Name: _____

Witness Signature (an adult other than the Health Care Representative):

Printed name of Witness: _____

Date: _____

INSTRUCTIONS

THESE DOCUMENTS
MUST BE
NOTARIZED—TAKE
THESE DOCUMENTS
TO A NOTARY PUBLIC
AND MAKE SURE YOU
SIGN THESE
DOCUMENTS IN THE
PRESENCE OF THE
NOTARY

Subscribed and acknowledged before me by _____,
the principal, this ____ day of _____, 20_____.

(notary public)

My Commission expires _____

Disqualification of certain individuals from health care treatment decisions

Just as you have the right to consent to your own health care directives under the law, you may also disqualify other people from making health care related decisions for you. In the absence of a written form disqualifying certain individuals from making health care decisions, certain relatives will be able to make health care decisions for you. If you do not appoint a health care representative and you do not disqualify someone from making health care decisions for you, then a spouse, either parent, an adult child, or an adult sibling related to you may be asked to make health care decisions for you if you are unable to do so for yourself.

In order to disqualify a person or people you must fill out the form, sign the form, and specifically write down the name of the person or people who are disqualified (not allowed) to make health care related decisions for you. You should give this disqualification to your doctor or to the person you designate as your health care power of attorney.

DISQUALIFICATION OF INDIVIDUAL(S) FROM MAKING HEALTH CARE DECISIONS

INSTRUCTIONS

PRINT THE DATE AND YOUR NAME

PRINT THE NAME OF THE PERSON OR PEOPLE YOU DO NOT WANT MAKING HEALTH CARE DECISIONS FOR YOU

CROSS OUT ANY UNUSED SPACES

SIGN AND PRINT YOUR NAME

PRINT YOUR CITY, COUNTY, AND STATE OF RESIDENCE

Declaration made this _____ day of _____, 20____, I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that the following person or people listed below are disqualified from making any and all health care decisions on my behalf:

Name of person disqualified: _____

Name of person disqualified: _____

Name of person disqualified: _____

Name of person disqualified: _____

In the absence of my ability to give directions regarding who may make health care decisions for me, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to disqualify a certain individual or individuals from making health care related decisions on my behalf.

I understand the full import of this declaration.

Signed: _____

Printed Name: _____

(City, County and State of Residence)

Understanding a Psychiatric Advance Directive

A psychiatric advance directive is a written instrument that discusses your preference and consent to treatment measures for a specific diagnosis for the care and treatment of any mental illness whenever you may become incapacitated as a result of mental illness.

In order to execute a psychiatric advance directive, you must execute the directive while you have the capacity to do so. Further, you must properly fill out the form, have your doctor fill out and sign the relevant section, and you must sign it.

You may include certain measures for the care and treatment of your mental illness during a period when you are incapacitated. These measures include the following:

- admission to an inpatient setting,
- whether prescribed medication should be given orally or by injection,
- use of physical restraint,
- use of seclusion,
- electroconvulsive therapy, or
- mental health counseling.

PSYCHIATRIC ADVANCE DIRECTIVE

INSTRUCTIONS

PRINT THE DATE AND YOUR NAME

SIGN YOUR INITIALS NEXT TO THE APPROPRIATE SPACES AND FILL OUT THE BLANKS, AS APPROPRIATE

YOUR PSYCHIATRIST MUST PRINT HIS OR HER NAME

YOUR PSYCHIATRIST MUST SIGN AND PRINT HIS OR HER NAME AND PRINT THE DATE

PRINT THE DATE AND YOUR NAME

SIGN YOUR INITIALS NEXT TO THE APPROPRIATE SPACES

Declaration made this _____ day of _____, 20____, I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires, preferences, and consent to the administration of treatment measures for a specific diagnosis for the care and treatment of any mental illness during subsequent periods of my incapacity. I declare as follows:

(Please fill out the following, as applicable.)

I. STATUTORY REQUIREMENTS.

_____ I am being treated or am otherwise enrolled at the following sponsoring facility or institution: _____

_____ My treating physician's name, address, and telephone number is:

_____ The name, address, and telephone number of any other mental health personnel who is treating me is:

_____ The name, address, and telephone number of my designated health care representative is:

II. ATTESTATION OF TREATING PSYCHIATRIST

I, _____, hereby attest that I am a psychiatrist who is treating the individual named in the psychiatric advance directive. I hereby attest that to the appropriateness of the individual's preferences stated in this psychiatric advance directive; and the individual named herein has the capacity to enter into the psychiatric advance directive.

Signed: _____

Printed Name: _____

Dated: _____

III. SPECIFICATIONS BY INDIVIDUAL.

Declaration made this _____ day of _____, 20____, I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires for certain measures for the care and treatment of my mental illness during a period when I am incapacitated, including:

_____ that I may be admitted to an inpatient psychiatric setting,

_____ that prescribed medication may be given to me orally,

_____ that prescribed medication may be given to me by injection,

_____ that physical restraint may be used to protect me,

_____ that seclusion from others may be used,

SIGN YOUR INITIALS
NEXT TO THE
APPROPRIATE SPACES

_____ that electroconvulsive therapy may be administered,
_____ that I may participate in mental health counseling.

In the absence of my ability to give directions when I am incapacitated due to a diagnosed mental illness, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to execute a psychiatric advance directive.

I understand the full import of this declaration.

Signed: _____

Printed Name: _____

(City, County and State of Residence)

Dated: _____

SIGN AND PRINT
YOUR NAME

PRINT YOUR CITY,
COUNTY, AND STATE
OF RESIDENCE

PRINT THE DATE YOU
SIGNED THE
DOCUMENT

LIFE PROLONGING PROCEDURES DECLARATION

INSTRUCTIONS

PRINT THE DATE AND YOUR NAME

SIGN AND PRINT YOUR NAME

PRINT THE DATE YOU SIGNED THE DOCUMENT

PRINT YOUR CITY, COUNTY, AND STATE OF RESIDENCE

HAVE TWO ADULT WITNESSES SIGN AND PRINT THEIR NAME AND PRINT THE DATE

Declaration made this _____ day of _____, 20____, I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain. In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed: _____

Printed Name: _____

Date: _____

(City, County and State of Residence)

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____ Date: _____

Printed Name: _____

**LIVING WILL DECLARATION
(Statutory Form)**

INSTRUCTIONS

PRINT THE DATE AND
YOUR NAME

SIGN YOUR INITIALS
NEXT TO THE
APPROPRIATE SPACE
(choose only one)

SIGN AND PRINT
YOUR NAME

PRINT THE DATE YOU
SIGNED THE
DOCUMENT

PRINT YOUR CITY,
COUNTY, AND STATE
OF RESIDENCE

HAVE TWO ADULT
WITNESSES SIGN AND
PRINT THEIR NAME
AND PRINT THE DATE

Declaration made this _____ day of _____, 20____, I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that:

- (1) I have an incurable injury, disease, or illness;
- (2) My death will occur within a short time; and
- (3) The use of life prolonging procedures would serve only to artificially prolong the dying process,

I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the provision of any medical procedures or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration.

(Indicate your choice by initialing or making your mark before signing this document.)

_____ I wish to receive artificially supplied nutrition and hydration even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney-in-fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of my refusal.

I understand the full import of this declaration.

Signed: _____

Printed Name: _____

Date: _____

(City, County and State of Residence)

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of declarant's estate. I am not directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____ Date: _____

Printed Name: _____

LIVING WILL DECLARATION
(With Provisions on Persistent Vegetative State)

INSTRUCTIONS

PRINT THE DATE AND
YOUR NAME

SIGN YOUR INITIALS
NEXT TO THE
APPROPRIATE SPACE
(choose only one)

SIGN YOUR INITIALS
NEXT TO THE
APPROPRIATE SPACE
(choose only one)

Declaration made this _____ day of _____, 20____, I, _____,
being at least eighteen (18) years of age and of sound mind, willfully and voluntarily
make known my desires that my dying shall not be artificially prolonged under the
circumstances set forth below, and I declare:

I. STATUTORY PROVISIONS.

If at any time my attending physician certifies in writing that:

- (1) I have an incurable injury, disease, or illness;
- (2) My death will occur within a short time; and
- (3) The use of life prolonging procedures would serve only to artificially prolong the dying process,

I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the provision of any medical procedures or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration.

(Indicate your choice by initialing or making your mark before signing this document.)

- _____ I wish to receive artificially supplied nutrition and hydration even if the effort to sustain life is futile or excessively burdensome to me.

- _____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

- _____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney-in-fact with health care powers under IC 30-5-5.

II. PERSISTENT VEGETATIVE STATE.

If at any time my attending physician certifies in writing that:

- (1) I am in a coma or a persistent vegetative state;
- (2) That is concluded to be irreversible by my attending physician; and
- (3) The use of life prolonging procedures would serve only to artificially prolong the dying process,

I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the provision of any medical procedures or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration.

(Indicate your choice by initialing or making your mark before signing this document.)

- _____ I wish to receive artificially supplied nutrition and hydration even if the effort to sustain life is futile or excessively burdensome to me.

- _____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

- _____ I intentionally make no decision concerning artificially supplied nutrition

and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney-in-fact with health care powers under IC 30-5-5.

III. PRIORITY OF LIVING WILL DECLARATION. The directives set forth in this Living Will Declaration:

(Indicate your choice by initialing or making your mark before signing this document.)

_____ Shall have precedence over the authority granted under any Power of Attorney for Health Care Decisions executed by me such that all actions of my Health Care Representative shall be in conformity with my directives as expressed in this Living Will Declaration.

_____ Shall be limited by and subject to the authority granted under any Power of Attorney for Health Care Decisions executed by me, it being my intentions that this Living Will Declaration in no way limit the discretionary authority conferred upon my Health Care Representative, but serve only as a guide in making health care decision.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of my refusal.

I understand the full import of this declaration.

Signed: _____

Printed Name: _____

(City, County and State of Residence)

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of declarant's estate. I am not directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____ Date: _____

Printed Name: _____

SIGN YOUR INITIALS
NEXT TO THE
APPROPRIATE SPACE
(choose only one)

SIGN AND PRINT
YOUR NAME

PRINT YOUR CITY,
COUNTY, AND STATE
OF RESIDENCE

HAVE TWO ADULT
WITNESSES SIGN AND
PRINT THEIR NAME
AND PRINT THE DATE

**OUT OF HOSPITAL DO NOT RESUSCITATE
DECLARATION AND ORDER**

INSTRUCTIONS

PRINT THE DATE AND
YOUR NAME

SIGN AND PRINT
YOUR NAME

PRINT YOUR CITY,
COUNTY, AND STATE
OF RESIDENCE

HAVE TWO ADULT
WITNESSES SIGN AND
PRINT THEIR NAME
AND PRINT THE DATE

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

**OUT OF HOSPITAL DO NOT RESUSCITATE
DECLARATION**

Declaration made this _____ day of _____, 20____, I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below. I declare:

My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital or a health facility, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this out of hospital Do Not Resuscitate declaration at any time by a signed and dated writing, by destroying or cancelling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration.

Signed: _____

Printed Name: _____

(City, County and State of Residence)

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of declarant's estate. I am not directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness Signature: _____ Date: _____

Witness Signature: _____ Date: _____

**OUT OF HOSPITAL DO NOT RESUSCITATE
ORDER**

INSTRUCTIONS

YOUR ATTENDING
PHYSICIAN MUST
PRINT HIS OR HER
NAME AND INDICATE
YOUR NAME IN THE
SECOND BLANK

YOUR ATTENDING
PHYSICIAN MUST
SIGN AND PRINT HIS
OR HER NAME, HIS OR
HER MEDICAL
LICENSE, AND PRINT
THE DATE

I, _____, the attending physician of _____,
have certified the declarant as a qualified person to make an out of hospital Do Not
Resuscitate declaration, and I order health care providers having actual notice of this out
of hospital Do Not Resuscitate declaration and order not to initiate or continue
cardiopulmonary resuscitation procedures on behalf of the declarant, unless the out of
hospital Do Not Resuscitate declaration is revoked.

Signed: _____

Printed Name: _____

Medical License Number: _____

Date: _____