West Jefferson Medical Center

Our *Family* Caring For Your *Family*™

Power of Attorney

For Health Care Decisions

I, _____, being of sound mind, do hereby designate:

_____, to serve as my Attorney-in-Fact, for the purpose of making medical treatment decisions for me (including the withholding or the withdrawal of life-sustaining procedures, nutrition, hydration) should I be diagnosed and certified as having a terminal and irreversible condition and be comatose, incompetent, or otherwise mentally or physically unable to make such decisions for myself.

Dated:_____ _____

(Declarant's signature)

Address:_____

City/state:_____

Parish:_____

The declarant has been personally known to me and I believe him/her to be of sound mind.

Dated:_____ _____ (Witness*)

Dated:_____ _____ (Witness*)

*The witnesses must be competent adults who are not related to the person making the declaration by blood or marriage and must not be entitled to inherit from the person making the declaration upon his/her death. A power of attorney for health care decisions must be in writing and may, but need not, be in this illustrative form. This form is being provided as a convenience to patients of West Jefferson Medical Center and should not be a substitute for legal advice.