DURABLE HEALTHCARE POWER OF ATTORNEY
(INCLUDING LIVING WILL, ADVANCE MEDICAL DIRECTIVE, AND ANATOMICAL GIFTS)
FOR
THE DISTRICT OF COLUMBIA, MARYLAND AND VIRGINIA

This form has three parts to state your wishes, and a fourth part for needed signatures. Part I of this form allows you to answer this question: If you cannot (or do not want to) make your own healthcare decisions, whom do you want to make them for you? The person you name is called your healthcare agent. ***Be sure you talk to your healthcare agent (and any back-up agents) about this important role.*** *You may also name individual(s) with whom your healthcare agent should consult. Part II allows you to write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In Part III, you may elect to become an organ donor after your death.*

You may fill out Parts I, II and III of this form, or only Part I, or only Part II, or only Part III. You should review the decisions contained in this document periodically, and if your wishes change, you should prepare a new healthcare power of attorney.

Be sure to give a copy of this completed form to your healthcare agent(s) and to your physician. Keep a copy at home in a place where someone will be able to locate it in the event of an emergency. A copy of this form has the same effect as the original document.

I, _____, date of birth _____, being of sound mind, willingly and voluntarily make known my wishes in this Durable Healthcare Power of Attorney and Advance Directive, as of the date indicated below.

PART I: SELECTION OF HEALTHCARE AGENT(S)

A. SELECTION OF AGENT

I, _____, residing at _____ _____, hereby appoint the following person as my primary agent to make healthcare decisions for me as authorized in this document:

_____
Name and Contact Information for Primary Agent

If the primary agent named above is not reasonably available, cannot be contacted in time, or for any reason is unavailable or unable or unwilling to act as my agent, then I appoint the following person to act in this capacity as authorized in this document:

_____
Name and Contact Information for Successor Agent

B. POWERS AND RIGHTS OF HEALTHCARE AGENT

I want, and hereby grant my agent, named above, to have full power and authority to make healthcare decisions for me, including, but not limited to, the following powers *(cross through any powers in this section that you do not want to give your Agent and add any powers or instructions that you do want to give to your Agent)*:

1. To consent to or refuse or withdraw consent to any type of healthcare, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration (including a ventilator), artificially administered nutrition and hydration (including feeding tubes), and cardiopulmonary resuscitation. This authorization specifically includes the authority to request a "Do Not Resuscitate" (DNR) order in my medical record, the power to consent to the administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or of inadvertently hastening my death.

2. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to, medical and hospital records, and the consent to the disclosure of this information.

3. To decide who my physician and other healthcare providers should be, including the authority to employ and discharge my healthcare providers.

4. To decide where I should be treated, including whether I should be in my home, a hospital, a nursing home, a hospice program, or other medical care facility, including the authority to transfer me from one facility or home to another.

5. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, assisted living facility or other medical care facility. If I have authorized admission to a healthcare facility for treatment of mental illness, that authority is stated below.

6. To continue to serve as my agent even if I protest the agent's authority after I have been determined to be incapable of making an informed decision about my healthcare, because the physician in charge of my care (attending physician) and a consulting physician have certified that I have lost this ability either temporarily or permanently.

7. To authorize the specific types of health care identified in this advance directive over my protest if, at the time, two physicians, one of whom shall be my attending physician, certify that that I am incapable of making an informed decision.

8. To authorize my participation in any healthcare study approved by an

institutional review board or research review committee according to the applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.

9. To authorize my participation in any healthcare study approved by an institutional review board or research review committee pursuant to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though the study offers no prospect of direct benefit to me.

10. [Transgender-specific:] To direct any healthcare provider, medical staff, or other person to address me by my name and gender pronouns of choice, and to preserve to the fullest extent possible an appearance consistent with my gender identity.

11. To take any lawful action that may be necessary to enforce the terms of this document, including seeking an order from a court of law to enjoin any act or decision contemplated hereunder. Further, my agent shall not be liable for the costs of health care pursuant to his authorization, based solely on that authorization.

12. I also want my agent to:

    a. Be permitted to ride with me in an ambulance if ever I need to be rushed to the hospital; and

    b. Be able to visit me if I am in a hospital or any other healthcare facility.

    c. To make decisions regarding visitation (i.e., who may visit me) during any time that I am admitted to any health care facility, consistent with the following directions: _____

    _____

The powers described above are subject to the following conditions or limitations: *(this is optional; form is valid if left blank; declarant may list any specific healthcare he/she does, or does not, want to receive)*

_____

_____

C. HOW MY AGENT IS TO DECIDE SPECIFIC ISSUES

I trust my agent to carry out my wishes and I trust my agent's judgment. My agent should first consider my preferences set forth in Part II of this DURABLE HEALTHCARE POWER OF ATTORNEY when making a medical decision for me.

Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. Based on these experiences, my agent should make a decision based on what I would want to do or would not want to do. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my physicians.

D. PEOPLE MY AGENT SHOULD CONSULT *(this is optional; form is valid if left blank)*

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent may consult or my agent's power to make decisions.

1. _____
   Name and Contact Information

2. _____
   Name and Contact Information

3. _____
   Name and Contact Information

E. ACCESS TO MY HEALTH INFORMATION – FEDERAL PRIVACY LAW (HIPAA) AUTHORIZATION

If, prior to the time the person selected as my agent has power to act under this document, my physician wants to discuss with that person my capacity to make my own healthcare decisions, I authorize my physician to disclose protected health information which relates to that issue.

Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

F. MENTAL HEALTH

_____1. If at any time (i) two physicians (one of whom shall be my attending physician) who have personally examined me certify in writing that I am incompetent, (ii) that I have a need for mental health services either during or as a result of the incompetency and (iii) that I am incapable of making an informed decision regarding

such services and related psychiatric care and treatment, I hereby direct my agent to select such mental health professional(s), program(s), facility(ies) and consent to the administration and/or withdrawal of such medications in accordance with my best interest.

>>OR<<

_____2. If at any time (i) two (2) physicians (one (1) of whom shall be my attending physician) who have personally examined me certify in writing that I am incompetent, (ii) that I have a need for mental health services either during or as a result of the incompetency and (iii) that I am incapable of making an informed decision regarding such services and related psychiatric care and treatment, then I hereby designate _____ (insert the name(s) of mental health professional(s), program(s) and facility(ies) you would prefer to provide such mental health services) and the administration of _____ (insert a statement of the medications you would prefer) in connection with such psychiatric treatment. I direct my healthcare providers to follow my preferences as set forth above to the extent that said physicians deem such professional(s), program(s), facility(ies) and the administration of such medications to be in my best interest.

G. EFFECTIVENESS OF THIS PART

*(Read both of these statements carefully. Then, initial **one** only.)*

My agent's power is in effect:

_____ 1. Immediately after I sign this document, subject to my right to make any decision about my healthcare if I want and am able to. This power of attorney shall not be affected by my subsequent incapacity.

>>OR<<

_____ 2. Whenever I am not able to make informed decisions about my healthcare, either because the physician in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting physician agree that I have lost this ability permanently. *However, I do want my agent to have the authority to ride with me in an ambulance and visit me in the hospital immediately, not only if I am unable to make informed decisions about my healthcare*.

PART II: TREATMENT PREFERENCES

(ADVANCE DIRECTIVE or "LIVING WILL")

STATEMENT OF GOALS AND VALUES *(Optional: Form valid if left blank)*

I want to say something about my goals and values, and especially what is most important to me during the last part of my life:

_____

_____

DECLARATION

I, _____, being 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 do declare as follows.

A. PREFERENCE IN CASE OF TERMINAL CONDITION

*(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)*

If two (2) physicians, who have personally examined me, one of whom shall be my attending physician, certify that my death from a terminal condition is imminent, even if life sustaining procedures are used:

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

>>OR<<

_____ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

>>OR<<

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

B. PREFERENCE IN CASE OF PERSISTENT VEGETATIVE STATE

*(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)*

If two (2) physicians, who have personally examined me, one of whom shall be my attending physician, certify that I am in a persistent vegetative state, that is, that I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

>>OR<<

_____ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

>>OR<<

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

C. PREFERENCE IN CASE OF END-STAGE CONDITION

*(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)*

If two (2) physicians, who have personally examined me, one of whom shall be my attending physician, certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

>>OR<<

_____ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

>>OR<<

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

D. PAIN RELIEF

_____ 1. No matter what my condition, give me the medicine or other treatment I need to relieve pain, even if such medication may hasten my death.

>>OR<<

_____ 2. I direct that, no matter what my condition, medication or other treatment not be given to me to relieve pain and suffering if such medication may hasten my death.

E. IN CASE OF PREGNANCY *(Optional; form valid if left blank)*

If I am pregnant, my agent shall follow these specific instructions:

_____ 1. I direct that my agent shall make any determination, in my agent's sole and absolute discretion, to provide, continue, withhold or withdraw life-sustaining measures during such pregnancy.

>>OR<<

_____ 2. I direct that my agent shall make any determination to provide, continue, withhold or withdraw life-sustaining measures during such pregnancy based upon my best interests and based upon my preference that my life not be prolonged through the use of such measures simply for the purposes of sustaining the pregnancy.

>>OR<<

_____ 3. I direct that my agent shall make any determination to provide, continue, withhold or withdraw life-sustaining measures during such pregnancy based upon the best interest of my infant in gestation.

Other instructions (optional): _____.

F. RESPECTFUL RELATIONS [Transgender-specific]

During any period of treatment, I direct my physician and all medical personnel to refer to me by the name of _____ irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any transition-related medical treatment.

During any period of treatment, I direct my physician ad all medical personnel to

use the _____ pronoun in reference to me, my chart, my treatment, etc., irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any transition-related medical treatment.

During any period of treatment, if I am unable to personally maintain my _____ appearance, I direct my physician and all medical personnel to do so to the extent reasonably possible, irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any transition-related medical treatment.

G. EFFECT OF STATED PREFERENCES

*(Read both of these statements carefully. Then, initial **one** only.)*

_____ 1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my healthcare providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

>>OR <<

_____ 2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my healthcare providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

PART III: AFTER MY DEATH

(This document is optional. Complete only the sections that reflect your wishes.)

A. ORGAN DONATION *(Initial the ones that you want. Cross through any that you do not want.)*

Upon my death I wish to donate:

_____ 1. Any needed organs, tissues, or eyes.

_____ 2. Only the following organs, tissues, or eyes

_____

_____

_____

I authorize the use of my organs, tissues, or eyes for any or all of the following uses:

_____ 1. For transplantation

_____ 2. For therapy

_____ 3. For research

_____ 4. For medical education

_____ 5. For any purpose authorized by law

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead under legal standards. *This section is not intended to change anything about my healthcare while I am still alive.* After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed.

I understand that my estate will not be charged for any costs related to this donation.

B. DONATION OF BODY

_____ After any organ donation indicated above, I wish my body to be donated for use in a medical study program.

_____ I do not want my body to be donated for use in a medical study program.

C. RESPECTFUL REMEMBRANCE [Transgender-specific]

During any memorial service or preparation thereof, I direct all coroners, funeral home employees, healthcare workers, and participants to refer to me by the name of _____ irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any transition-related medical treatment.

During any memorial service or preparation thereof, I direct all coroners, funeral home employees, healthcare workers, and participants to use the _____ pronoun in reference to me, my chart, my treatment, etc., irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any transition-related medical treatment.

During any memorial service or preparation thereof, I direct all coroners, funeral home employees, healthcare workers, and participants to maintain my _____ appearance, irrespective of whether I have obtained a court-ordered name change, changed my gender marker on any identification document, or undergone any transition-related medical treatment.

PART IV: DECLARATION, SIGNATURE AND WITNESSES

My Agent is authorized to make photocopies of this instrument as frequently and in such quantity as my Agent shall deem appropriate. Each photocopy shall have the same force and effect as any original. This instrument and actions taken by my Agent properly authorized hereunder shall be binding on me, my estate and my personal representative.

[*Optional:* My physician or licensed clinical psychologist hereby attests that I am capable of making an informed decision at this time and that I understand the consequences of the provisions of my advance directive: _____].

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this Durable Healthcare Power of Attorney and Advance Directive, and that I understand its purpose and effect. I also understand that this document replaces any similar healthcare power of attorney and/or living will and/or advance directive I may have completed before this date.

I understand I may revoke all or any part of this document at any time (i) with a signed, dated writing; (ii) by physical cancellation or destruction of this advance directive by myself or by directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke.

I intend that this document be valid under the laws of the District of Columbia, Virginia, and Maryland, and that it be recognized as my wishes by these and any other jurisdiction in which I may be located.

_____ _____

Declarant's Signature **Date**

_____, known to me (or satisfactorily proven) to be the Declarant, signed or acknowledged signing the foregoing and annexed Durable Healthcare Power of Attorney and Advance Directive (Living Will) in my presence, and, based upon my personal observation, the Declarant appears to be an emotionally and mentally competent individual, of sound mind and under no duress, fraud, or undue influence. In addition:

i. I am at least 18 years of age;
ii. I did not sign the declarant's signature, above, for or at the direction of the declarant;
iii. I am not a person appointed as Agent by this Durable Healthcare Power of Attorney;
iv. I am not a primary physician or health-care provider of the principal, or an employee of a primary physician or health-care provider of the principal, or an employee of a health care facility of which the principal is a patient;
v. I am not related to the Declarant by blood, marriage, domestic partnership, or adoption, nor am I a spouse, a lineal ancestor, a descendant of the Declarant or of the parents of the Declarant, or a spouse of any of them;
vi. I am not directly or indirectly financially responsible for the Declarant’s medical care;

vii. I am not, to the best of my knowledge, entitled to any part of the Estate of the Declarant under a currently existing Will (or Codicil thereto), Trust Agreement, life insurance policy, or by operation of law (including the laws of intestate succession of the District of Columbia), and consequently will not financially gain as a result of the Declarant's death.

Witness Signature Date	Witness Signature Date
Printed Name	Printed Name
Address	Address
Telephone:	Telephone:

_____)
) **ACKNOWLEDGEMENT**
_____)

NOTARIAL ACKNOWLEDGMENT. Before me, the undersigned authority, on this day, personally appeared [full name of Declarant]**,** the Declarant, and

_____, _____,
known to me (or satisfactorily proven to me) to be the Declarant and the witnesses, respectively, whose names are signed to the attached or foregoing instrument, and (all of these persons being first duly sworn by me): the Declarant, _____, signed the foregoing Durable Healthcare Power of Attorney and Advance Directive (Living Will) dated the _____ day of _____, 20___, and declared to me and to the witnesses in my presence that he willingly signed the same and executed it in the presence of said witnesses and me as his free and voluntary act and deed for the purposes therein expressed; whereupon the witnesses, in my presence, also signed the same foregoing instrument and attested to all of the facts subscribed above.

GIVEN under my hand and seal the _____ day of _____, 20___.

_____
Notary Public
My Commission Expires:
(Notarial Seal)