MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS (MDPOA)

NAME OF
DECLARANT_____DOB_____

ADDRESS_____ PHONE#_____

1. Appointment of Agent and Alternates

I, the Declarant, hereby appoint:

_____

Name of Agent- Relationship

_____

Agent's Best Contact Telephone Number

_____

Agent's Home Address

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, refuse, or stop any healthcare, treatment, service or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

_____

Name of Alternate Agent #1- Relationship

_____

Agent's Best Contact Telephone Number

_____

Agent's Home Address

_____

Name of Alternate Agent #2- Relationship

_____

Agent's Best Contact Telephone Number

_____

Agent's Home Address

2. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines to be in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

Optional: State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

_____

_____

_____

_____

My signature below indicates that I understand the purpose and effect of this document. I do hereby revoke and cancel any and all prior Medical Powers of Attorney that I may have previously done and executed:

_____

Signature of Declarant *Date*

3. Signature of Witnesses and Notary (Optional)

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We are at least eighteen (18) years old.

_____

Signature of Witness

_____

Printed Name

_____

Address

_____

Signature of Witness

_____

Printed Name

_____

Address

Notary (Optional)

State of _____

County of _____

SUBSCRIBED and sworn to before me by _____, the Declarant, as the voluntary act and deed of the Declarant this_____ day of _____, 20_____

Notary Public_____

My commission expires: _____