PROXIMITI HEALTH

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COLORADO MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I. APPOINTMENT OF AGENT AND ALTERNATES

I, _____ ,
Declarant, hereby appoint:

_____
Name of Agent

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative 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, or 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

_____
Name of Alternate Agent 1

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

_____
Name of Alternate Agent 2

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

II. WHEN AGENT'S POWERS BEGIN

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either **(*initial one*)**:

_____ (*Initials*) Immediately upon my signature.

_____ (*Initials*) When my physician or other qualified medical professional has determined that I am unable to make my or express my own decisions, and for as long as I am unable to make or express my own decisions.

III. 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 is 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.

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:

_____
Signature of Declarant *Date*

ADDENDUM TO MEDICAL DURABLE POWER OF ATTORNEY – RECOMMENDED, NOT REQUIRED

1. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (*name of Declarant*)

_____

I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

_____
Primary Agent's Signature

_____
Printed Name

_____
Date

_____
Alternate Agent #1 Signature

_____
Printed Name

_____
Date

_____
Alternate Agent #1 Signature

_____
Printed Name

_____
Date

2. Signature of Witnesses and Notary

The signature of two witnesses and a notary seal 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 by (*name of Declarant*)

_____

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 declare that, at the time the Declarant signed this document, we believe that he or she was of sound mind and under no pressure or undue influence. We are at least eighteen (18) years old.

_____
Signature of Witness *Date*

_____
Printed Name

_____
Address

_____

_____
Signature of Witness *Date*

_____
Printed Name

_____
Address

_____

Notary Seal (optional)

State of _____

County of _____}

SUBSCRIBED and sworn to before me by

_____, the Declarant,

and _____

and _____

witnesses, as the voluntary act and deed of the Declarant

this day _____ of _____, 20_____.

_____
Notary Public

My commission expires:_____

DISCLAIMER: *The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.*