Durable Power of Attorney for Healthcare Decisions

DECLARATION

STATE OF LOUISIANA, PARISH OF_____

Declaration made this _____day of _____ , 20_____.

I,_____, being of sound mind, willfully and voluntarily hereby make known my desire that

_____,_____, _____,

Name *Address* *Phone Number*

bearing the relationship of _____ to me be designated as the individual to make any and all treatment decisions for me in the event that I should become comatose, incompetent or otherwise mentally or physically incapable of communication.

Consistent with the forgoing (and except to the extent necessary to give full effect to the provisions of any valid document executed by me providing for the donation of any of my organ(s), I further specifically authorize the person named above to make any and all decisions with regard to withholding or withdrawing life-sustaining procedures in the event that I should be certified by two (2) physicians who have personally examined me (one of whom shall be my attending physician) to be suffering from a terminal and irreversible condition or to be in a continual profound comatose state with no reasonable chance of recovery, and the said physicians determine that the application of life-sustaining procedures would serve only to prolong artificially the dying process.

In the event that the individual named above cannot be located when the need arises, or in the event that the individual named above is or becomes incapable to serve in the capacity indicated herein (and subject to the above exception), it is my express wish and directive that my dying shall not be artificially prolonged under the following circumstances. If, at any time, I should have an incurable injury, disease or illness and be certified by two (2) physicians who have personally examined me (one of whom shall be my attending physician) to be suffering from a terminal and irreversible condition, or to be in a continual profound comatose state with no reasonable chance of recovery, and the said physicians determine that the application of life-sustaining process, I (subject to the above exception) direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedures deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life sustaining procedures and in the absence of a decision for whatever reason exception) this declaration be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment as provided herein and accept the consequences from such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

This declaration is made and signed by me in the presence of the undersigned witnesses who are not related to me by blood or marriage.

_____

Signature of Declarant

This declarant is personally known to me, and I believe the declarant to be of sound mind.

Witness_____

Witness_____