INDIANA HEALTH CARE POWER OF ATTORNEY
(And Providing For a Successor)

State of Indiana, County of _____, SS

KNOW ALL PERSONS BY THESE PRESENTS, that I, _____

as principal, do hereby make, constitute, and appoint:

(Name of attorney-in-fact) _____

(Address) _____

(Home Telephone) _____ (Work/Cell phone) _____

as my true and lawful attorney-in-fact for me, in my name, place, and stead, and on my behalf to exercise general authority with respect to health care powers as the same are described in IC 30-5-5-16 and -17. If the attorney-in-fact first named above should be unable or unwilling to service in such capacity, I appoint:

(Name of successor attorney-in-fact) _____

(Address) _____

(Home Telephone) _____ (Work/Cell phone) _____

to serve as such attorney-in-fact. In accord with the provisions of those statutes, I attach hereto and incorporate herein my appointment of my attorney-in-fact as my health care representative under IC 16-36-1 as follows.

APPOINTMENT OF REPRESENTATIVE
TO CONSENT TO HEALTH CARE

I, the principal named above, in accord with the provisions of IC 16-36-1-7, do hereby appoint my attorney-in-fact named above as my representative to act for me in matters affecting my health.

My representative may delegate the authority herein granted in accord with the provisions of IC 16-36-1-6, but only during a period when my representative may not be reasonably available to exercise the authority in person.

This appointment shall be effective from this date forward and shall remain in effect until I revoke the same by notifying my representative or the health care provider orally or in writing.

My representative's authority to act for me in matters affecting my health (to consent to health care or to withhold such consent) shall commence when and if I become incapable of so acting

on my own, and such authority shall abate when and if I once again become capable of so acting on my own.

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis or prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and my consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

In the exercise of the authority granted, to my representative by this appointment, my representative shall act in my best interests consistent with the purposed expressed herein, and my representative shall act in good faith.

IN WITNESS of the foregoing HEALTH CARE POWER OF ATTORNEY and of the foregoing APPOINTMENT OF REPRESENTATIVE TO CONSENT TO HEALTH CARE, I hereunto set my hand.

_____ _____

(Principal) *(Date)*

STATE OF INDIANA, COUNTY OF _____, SS

Before me, the undersigned, a notary public in and for the said county and state and an adult other than the representative named in the foregoing document, this _____ day of _____, _____ personally appeared _____, signed the foregoing Health Care Power of Attorney and Appointment for Representative to Consent to Health Care and acknowledged execution of the same as _____ free and voluntary act and deed. Witness my hand and notarial seal.

_____

(Signature of Notary Public)

_____

(Printed or typed name)

My Commission Expires: _____

My County of Residence is: _____