HEALTH CARE POWER OF ATTORNEY

I, _________________, of _________________, Arizona, as Principal, designate:

Agent Name: _________________

Address: _________________

_________________, _________________ _________________

Home Phone: _________________

Work Phone: _________________

as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care, including the provision of life-sustaining treatment and artificially administered food and fluids. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and person representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

FIRST ALTERNATE AGENT

Agent Name: _________________

Address: _________________

_________________, _________________ _________________

Home Phone: _________________

Work Phone: _________________

SECOND ALTERNATE AGENT

Agent Name: _________________

Address: _________________

_________________, _________________ _________________

Home Phone: _________________

Work Phone: _________________

I have not completed or attached a living will.

SAMPLE

I have completed a prehospital medical directive pursuant to section 36-3251, Arizona Revised Statutes.

If any provision in this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

AUTOPSY. (Under Arizona law an autopsy may be required.) If you wish to do so, reflect your desires below: **I do not consent to an autopsy.**

FUNERAL AND BURIAL DISPOSITION. My agent has authority to carry out all matters relating to my funeral and burial disposition wishes in accordance with this power of attorney, which is effective upon my death.

My agent may make all funeral and burial disposition decisions.

This health care directive is made under section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

Signed on _____ day of _______________, _____.

Signature: ____
Name: __________________
Address: __________________
__________________ County
Arizona

Birthdate: Invalid date

STATEMENT OF WITNESS

I am an adult, and I was present when __________________ signed (or marked) this Health Care Power of Attorney. __________________ appeared to be of sound mind and free from duress at the time of signing. I am not designated as agent or alternate agent by this document to make medical decisions on __________________'s behalf, and I am not a person directly involved with the provision of health care to __________________ at the time this Health Care Power of Attorney was signed by __________________.

I am not related to __________________ by blood, marriage or adoption and to the best of my knowledge, I am not entitled to any part of __________________'s estate by will or by operation of law at the time this Health Care Power of Attorney was signed by __________________.

SAMPLE

Witness Signature: ____

Name: ________________________________
Address: ________________________________
____
____

Date: _________________________

SAMPLE