POWER OF ATTORNEY FOR HEALTH CARE

WARNING TO PERSON SIGNING THIS DOCUMENT:

This is an important document. Before signing it, you should know these important facts.

This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, it gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent authorizes anything that is illegal or acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to authorize an autopsy, to donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and to direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

I, ____ *[printed name]*, of

________________________________ County, Tennessee, affirm that I have read the statement above concerning the legal consequences of my signing this document.

I appoint ____ *[printed name]* as my attorney-in-fact to have the authority set forth below. In the event the person I appoint above is unable, unwilling or unavailable to act

as my attorney-in-fact, I hereby appoint ____________________________________ *[printed name].*

I have discussed (or will discuss) my wishes about health care with my attorney-in-fact and my alternate attorney-in-fact. I authorize them to make any and all health care decisions for me, including decisions to withhold or withdraw any form of life support. I enable them to contract for my entry into, or to arrange my release from, any hospital, nursing home, or other type of health care center.

This power of attorney becomes effective when one doctor determines that I can no longer make my own medical decisions. It shall not be terminated by my disability or incapacity. If I recover the ability to make medical decisions for myself, this document shall no longer be in effect.

In determining whether I am terminally ill, permanently unconscious, or in the final stages of a progressive illness, the opinion of two physicians shall be required.

I reserve the right to revoke or revise this document at any time when I am not disabled.

A copy of this document shall have the same effect as the original, whether or not it is certified by a notary public or a governmental official as a true copy, so long as the person receiving it believes it to be genuine.

I have signed this document on the ________day of _____________________, 20____.

____

Signature of Principal

I declare under penalty of perjury under the laws of Tennessee that the person who signed this document (the principal) is personally known to me or has been proven by satisfactory evidence to be the person stated above; that the principal signed this Durable Power of Attorney for Health Care in my presence; that the principal appears to be of sound mind and under no duress, fraud or undue influence; that I am not the person appointed as attorney-in-fact by this document; that I am not a health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution; that I am not related to the principal by blood, marriage, or adoption; that, to the best of my knowledge, I do not, at the present time, have a claim against any portion of the estate of the principal upon said person's death; and, that, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will or codicil thereto now existing, or by operation of law.

____	____
Witness	Witness
____	____
Address	Address
____	____
City, State, Zip Code	City, State, Zip Code

STATE OF TENNESSEE COUNTY OF ____________________

On this the ________ day of _________________, in the year 20___, before me, the undersigned notary public, personally appeared the person who is named above, who is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

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Notary Public

My commission expires:___________________________