Generations Hospice
Service Corporation

Durable Power of Attorney Declaration

INSTRUCTIONS

PRINT YOUR NAME

I, ____, being of sound mind,

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR AGENT

do hereby designate, ____,

residing at ____ ,

and whose telephone number is (_____) ______ - __________, to serve as my attorney-in-fact for the purpose of making treatment decisions for me should I be comatose, incompetent, or otherwise mentally or physically unable to make such decisions for myself. Such treatment decisions include, but are not limited to, decisions concerning surgery, medications, physician selection, hospitalization, comfort care, intravenous infusions, nasogastric tube feedings, nursing home placement and the withholding/withdrawal of life sustaining procedures in the event I am diagnosed and certified as having a terminal and irreversible illness or condition.

Such attorney has full authority to make such decisions for me as if such decisions had been personally made by me. This declaration is intended to replace and supersede any such declaration previously made by me.

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

PRINT THE DATE

Thus done and signed this ______ day of ____________________, 20_____.

SIGN THE AND PRINT YOUR PLACE OF RESIDENCE

Signed ____

City, Parish and State of Residence _________________________________

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WITNESSES MUST SIGN HERE
-WITNESSES CANNOT BE RELATED BY BLOOD
-WITNESSES CANNOT BE ENTITLED TO ANY PORTION OF YOUR ESTATE

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness_________________________ _________________________
Printed Name *Signature*

Witness _________________________ _________________________
Printed Name *Signature*