# DURABLE POWER OF ATTORNEY FOR HEALTH CARE

## I. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this important legal document, I hereby create a durable power of attorney for health care pursuant to South Dakota Codified Law. This power of attorney shall not be affected by my subsequent incapacity and shall only become effective upon the incapacity of myself.

## II. STATEMENT OF PURPOSE

By the creation of this legal document I instruct my agent that it is my wish and intent to follow the moral teachings of the Catholic Church and to receive all the obligatory care that my faith teaches that I, as a child of God, have a duty to accept. This is to be considered the guiding principle of this document. However, I also know the Catholic Church teaches that death need not be resisted by any and every means and that I have a right to refuse medical treatment that is extraordinary or excessively burdensome and would only prolong my death. I also realize that I may morally receive medication to relieve pain even if it is foreseen that its use may have the unintended result of shortening my life.

## III. DESIGNATION OF AGENT (ATTORNEY-IN-FACT)

**As the Principal, I,** _____,
(Name)

born on _____ and residing at
(Birth date)

_____,
(Address)

**do hereby designate and appoint:**

NAME: _____

ADDRESS: _____

_____

PHONE: _____

**as my agent (attorney-in-fact) to make any and all health care decisions on my behalf should I ever become incapacitated.**

## IV. GENERAL STATEMENT OF AUTHORITY GRANTED.

Subject to the limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make those decisions for myself if I had the capacity to do so.

The power and authority granted to my agent in this document is effective only if I am unable to give informed consent with respect to health care decisions, and only for the duration of my inability to make such decisions.

In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent.

## V. STATEMENT OF SPECIAL PROVISIONS, DIRECTIONS, AND LIMITATIONS.

I have discussed my principles and beliefs with my agent. I trust my agent to make appropriate health care decisions on my behalf based upon past and future discussions, subject only to the limitations, provisions and directions expressed in this document.

A. This document is intended to confer legal immunity on my agent unless my agent is not acting in accordance with the limitations, provisions and directions expressed in this document.

B. Only this document, which bears my original signature, is to be considered legally valid. A photocopy of this signed document is to be used for informational purposes only. However, a copy of this document may be certified or notarized by an official of the state or someone who is authorized to make such certifications, in such case, a certified or notarized copy thereof shall have the same force and effect as the signed original.

C. I clearly intend that, if I am unable to make health care decisions, my agent may make the health care decisions for me that I could have made individually if I had decisional capacity. I expressly eliminate any authority of any health care provider or any agent or employee of a health care provider to petition the court to remove or replace my agent.

D. I direct my agent to use the power and authority granted in this document to insure (by taking legal action, if necessary) that my rights are protected. Such power and authority to include, but not limited to, access to medical records and information, to employ and discharge personnel responsible for my healthcare, to authorize admission to or discharge from a facility or service, and any other necessary actions related to my care and treatment.

E. I direct that my agent not be held personally financially responsible for decisions and actions taken to carry out my wishes related to health care decisions.

F. I direct that my agent request and consent to care, treatment, services and procedures, including palliative care, which are appropriate to my condition and are beneficial for me, subject only to the limitations, provisions and directions expressed in this document. The meanings of the words "not appropriate" and "not beneficial", for the purpose of this direction, are those which I have discussed with my agent.

G. I authorize my agent to withhold or withdraw consent to care, treatment, services and procedures which are not appropriate to my condition and are not beneficial for me, subject only to the limitations, provisions and directions expressed in this document. The meanings of the words "not appropriate" and "not beneficial", for the purpose of this direction, are those which I have discussed with my agent.

H. I direct that there should be a strong presumption in favor of providing me with nutrition and hydration (food and water), which my faith considers to be ordinary care, unless death is inevitable and truly imminent so that the effort to sustain my life is futile or unless I am unable to assimilate food and fluids. The meaning of the words "imminent" and "futile", for the purpose of this direction, are those I have discussed fully with my agent.

I. I have discussed with my agent the topic of "do not resuscitate" (DNR) orders and I direct that my agent shall make the determination of whether or not a DNR is appropriate for me.

J. I direct that my life not be ended by assisted suicide.

K. I direct that my life not be ended by euthanasia. For the purpose of this direction, "euthanasia" means an action or omission which would directly and intentionally cause my death.

## VI. DESIGNATION OF ALTERNATE AGENTS

If the person designated as my agent in paragraph III is not reasonably available, becomes ineligible to act as my agent, loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent, then I designate and appoint the following persons, in order of preference, to serve as my agent to make health care decisions for me as authorized in this document.

These persons, to serve in the order listed below, are:

**A.** NAME: _____

ADDRESS: _____

_____

PHONE: _____

**B.** NAME: _____

ADDRESS: _____

_____

PHONE: _____

## VII. NOMINATION OF GUARDIAN.

If it becomes necessary that a guardian or conservator of the person be appointed for me, I nominate the same individuals, in the same order of preference, as those appointed to serve as my agent and alternate agent(s).

## VIII. REVOCATION OF PRIOR ADVANCE DIRECTIVES.

I revoke any and all prior living will or durable power of attorney for health care documents.

## DATE AND SIGNATURE OF PRINCIPAL

I sign my name to this Durable Power of Attorney for Health Care on this _____ day of _____, 20__ at _____ (City), _____ (State).

_____
Principal

**WITNESSES**

We, _____, _____, sign our names to this legal document, being first duly sworn, do hereby declare to the undersigned authority, that the principal signs and executes this document willingly, and executes it free and voluntarily for the purposes therein expressed, and that each of us as witnesses, in the presence and hearing of the principal, hereby sign this document as witness to the principal's signing, and that to the best of our knowledge the principal is 18 years of age or older, of sound mind, and under no constraint or undue influence. As witnesses, we testify that we are not the person appointed as agent in this document.

_____ _____
Witness Date

_____
Print Name

_____
Address

_____ _____
Witness Date

_____
Print Name

_____
Address

The State of South Dakota
County of _____

Subscribed, sworn to, and acknowledged before me by_____ the Principal, and sworn to before me by_____ and_____, Witnesses, this ____ day of _____, 20___.

_____
Notary Public
(Seal) My Commission Expires: _____