Durable Power of Attorney *for Health Care*

Fill out this document carefully. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will be in effect unless or until you revoke it. You may change or revoke this document at any time by telling your doctor and other healthcare providers. You should give copies of this document to your family, your doctor and your health care facility. This form is optional. If you choose to use this form, the form has a signature line for you and a notary.

I,_____, _____ appoint _____
(Principal/Patient) *(Birthday)* *(Decision Maker/Agent)*

as my Attorney-In-Fact for the purpose of making healthcare decisions on my behalf. In the event the person named above is unable or unwilling to act as my Attorney-In-Fact, I appoint

(Optional) _____ as my Attorney-In-Fact. In the event both of the previously named persons are either unable or unwilling to act as my Attorney In Fact, I appoint

(Optional) _____ as my Attorney-In-Fact. This Power of Attorney shall become effective upon my disability as authorized by SD Codified Law §§ 59-7-2.1-2.8.

I grant my Attorney-In-Fact the power to:

(Initial) _____ Make any and all health care decisions on my behalf, including each of the powers identified in items 1-7 below:

OR

I only grant my Attorney-In-Fact the power to (initial each power granted):

1) _____ Consent to healthcare on my behalf.
2) _____ Withdraw consent for healthcare.
3) _____ Reject care or treatment recommended by a healthcare provider in accordance with my previously stated wishes.
4) _____ Authorize a healthcare provider to withhold care or treatment when such care or treatment would prolong my suffering.
5) _____ Authorize artificial nutrition to be withheld or withdrawn.
6) _____ Authorize artificial hydration to be withheld or withdrawn.
7) _____ Other /Additional Instructions (specify): _____

_____

Dated this, the_____day of _____, 20 _____. _____
(Principal/Patient)

Document can be completed with two (2) adult witnesses or a notary.

Witness Name PRINT: _____

Witness Signature: _____ Date: _____ Time: _____

Witness Name PRINT: _____

Witness Signature: _____ Date: _____ Time: _____

State of South Dakota)
) ss
County of _____)

On this _____ day _____ ,20 _____ , _____, known to me or satisfactorily proven to be the person named above, personally appeared before me, a Notary Public with the State of South Dakota, and acknowledged that he or she executed the same for the purposes stated herein.

Notary Public _____

My commission expires _____

Seal