Acceptance of Health Care Agent Role

I, _____ accept the role of Health Care Agent for_____(the patient).

Signature: _____Date: _____

I, _____ accept the role of next Health Care Agent_____(the patient).

Signature: _____ Date: _____

MHCC-10239 Rev. (2/15)

Attention Michigan Health Care Providers

I have created the following Advanced Directives:
(Check one or more, as appropriate)
☐ Durable Power of Attorney for Health Care
☐ Other _____
_____

Please contact _____
(name)
_____
(address)
_____for more information.
(phone)

_____ _____
date signature

Attention Michigan Health Care Providers

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(Check one or more, as appropriate)
☐ Durable Power of Attorney for Health Care
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Please contact _____
(name)
_____
(address)
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(phone)

_____ _____
date signature

Wallet Cards for Michigan Advance Directives

Complete the cards and punch out. Put one card in your wallet or purse that you carry most often, along with your driver's license or health insurance card. Keep the second on your refrigerator, in your motor vehicle glove compartment, a spare wallet or purse, or any easy-to-find place.

McLaren
HEALTH CARE

Health Care Agent Appointment (Medical Power of Attorney)

I, _____ make this my Health Care Agent appointment (also called Medical Power of Attorney). I am of sound mind. If the time comes when I can no longer take part in decisions about my health, these instructions should be used to follow my wishes.

This Health Care Agent appointment is effective only if I am unable to make my own medical or mental health care decisions. It will remain in effect unless I cancel this appointment or my Health Care Agent wants to stop being my agent. I can cancel this appointment at any time and in any manner that states my wish. If a mental health decision must be made, there will be a 30-day delay after I state my wish to cancel this appointment.

Choose one Philosophy of Health Care

____ I believe as long as there is life there is hope. I want any and all treatments offered to me to continue my life. I am willing to accept the effects of all of treatment used. This may include life with a feeding tube, dialysis, or life on a breathing machine if I am unable to breathe on my own. I am willing to live in a constant vegetative state.

____ I am willing to undergo many tests, surgery, and short-term breathing machine treatment in an effort to continue my life. If the time should come when there is no reasonable hope of my recovery from physical disability or terminal illness, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures."
I ask that then medicine be given only to ease suffering even though this may allow my death to occur.

____ I do NOT want to undergo many tests, surgery, or short-term treatment on a breathing machine in an effort to continue my life. I only want basic medical care, such as treatment for infections and minor surgeries for a condition that can be helped or to control pain. If my condition gets worse or there is no hope for my recovery, I ask that medicine be given to ease suffering even though this may allow my death to occur.

____Comfort is my main concern. I have received the news that my condition cannot be cured. I now choose only to be kept comfortable.

____ Other: I want the following care/types of care:
_____
_____
_____
_____

Organ Donation

____ (Yes or No) I wish to donate an organ or tissue from my body after my death, and I authorize my Health Care Agent to donate the following after my death:

____ Any or all organs and tissue possible; or
____ The following organ(s) and/or tissue:_____
_____

Role of the Health Care Agent

My Health Care Agent has the power to make all medical or mental health decisions for me as instructed above.

My Health Care Agent cannot make the decision to withdraw or withhold treatment that may result in my death unless I have granted consent as stated above. My Health Care Agent cannot withhold or stop treatment from me that would result in my death, if I am pregnant.

My Health Care Agent shall act in accordance with the current treatment guidelines recognized by the medical community. My Health Care Agent cannot make a treatment decision that is against medical standards or that I could not have made for my self. My Health Care Agent shall act according to my best interests and desires. My known desires, written or spoken, while I was able to participate in medical or mental health treatment decisions are assumed to be in my best interests.

A patient admitted to a health care facility or agency has the rights listed in section 20201 of the Public Health Code, 1978 PA 368, MCL 333.20201. These are known as “Patient Rights.”

My Health Care Agent will only have the power to make medical decisions for me if I am unable to make those decisions.

My Health Care Agent will not be paid for being my Health Care Agent. However, he/she can be paid back for actual and necessary costs of being my Health Care Agent. My Health Care Agent has the right to stop being my Health Care Agent any time and in any way that states his/her wish to cancel.

I, _____ choose the following person to be my Health Care Agent.

My Health Care Agent shall be:

Name: _____

Address: _____

City: _____State: _____ Zip Code:_____

Phone: (home)_____ (work) _____

(Other)_____

Signature: _____Date: _____

If my Health Care Agent stops being my Health Care Agent or if my Health Care Agent is not available to make decisions for me, I name the following person as my next Health Care Agent.

My next Health Care Agent shall be:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (home) _____ (work) _____

You must have two adult witnesses. They cannot be your spouse, parent, child, grandchild, sibling, presumptive heir, doctor, an employee of your life or health insurance agent or company, an employee of a health facility that is treating you, or an employee of a home for the aged where you live at the time of the witnessing.

Statement of Witnesses

As witnesses, this form was signed in your presence.
The declarant appears to be of sound mind, is making this designation voluntarily, and under no duress, fraud, or undue influence.
You are only witnessing the signature of the patient.

Witness (1) Signature:_____

Print full name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Date: _____

Witness (2) Signature: _____

Print full name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Date: _____