



800 East 21st Street
 PO Box 5045
 Sioux Falls, SD 57117-5045
 (605) 322-8000



ADVA DIR

1. Designation of Health Care Agent

I, _____, hereby appoint:
 (Principal) (Date of Birth)

 (Agent's Name)

 (Address)

Home Telephone: _____ Work Telephone: _____

as my Agent to make health and personal care decisions for me as authorized in this document.

2. Effective Date and Durability

By this document I intend to create a durable power of attorney effective upon, and only during any period of incapacity in which, in the opinion of my Agent and attending physician, I am unable to make or communicate a choice regarding a particular health care decision.

3. Agents Powers

I grant to my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or otherwise known to my Agent. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interests. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, unless specifically limited by Section 4, below, my Agent is authorized as follows:

- A. To consent, refuse or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnosis procedures, medication and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutrition support and hydration, and cardiopulmonary resuscitation;
- B. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
- C. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service;
- D. To contract on my behalf for any health care related service or facility without my Agent incurring personal financial liability for such contracts;
- E. To hire and fire medical, social service and other support personnel responsible for my care;
- F. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death;



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- G. To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law;
- H. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to seek actual or punitive damages for the failure to comply.

4. Statement of Desires, Special Provisions, and Limitations

- A. The powers granted above do not include the following powers or are subject to the following rules or limitations:

- B. With respect to any life-sustaining treatment, I direct the following: (Initial only one of the following paragraphs)

_____ **Reference to Living Will.** I specifically direct my Agent to follow any health care declaration or "living will" executed by me.

_____ **Grant of Discretion to Agent.** I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my Agent believes the burdens of the treatment outweigh the expected benefits. I want my Agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

_____ **Directive to Withhold or Withdraw Treatment.** I do not want my life to be prolonged and I do not want life-sustaining treatment.

1. If I have a condition that is incurable or irreversible and, without the admission of life-sustaining treatment, expected to result in death within a relatively short period of time; or
2. If I am in a coma or persistent vegetative state which is reasonably concluded to be irreversible.

_____ **Directive For Maximum Treatment.** I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

_____ **Directive In My Own Words:**



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C. With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines or veins, I wish to make clear that: (Initial only one)

_____ I intend to include these procedures among the “life-sustaining procedures” that may be withheld or withdrawn under conditions given above.

_____ I do not intend to include these procedures among the “life-sustaining procedures” that may be withheld or withdrawn.

5. Successors.

If any Agent named by me shall die, become legally disabled, resign, refuse to act, be unavailable, or (if any Agent is my spouse) be legally separated or divorced from me, I name the following (each to act alone and successively, in the order named) as successors to my Agent.

A. First Alternate Agent: _____

Address: _____

Telephone: _____

B. Second Alternate Agent: _____

Address: _____

Telephone: _____

6. Protection of Third Parties Who Rely On My Agent.

No person who relies in good faith upon my representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent’s authority.

7. Nomination of Guardian.

If a guardian of my person should for any reason be appointed, I nominate my Agent (or his or her successor), named above.

8. Administrative Provisions.

A. I revoke any prior power of attorney for health care.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

C. My Agent shall not be entitled to compensation for services performed under this power of attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.

D. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.



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**By Signing Here I Indicate That I Understand The Contents Of This Document
 And The Effect Of This Grant of Powers To My Agent.**

I sign my name to this Durable Power of Attorney for Healthcare on this _____ Day of _____ .
 (Month and Year)

Signature: _____

Name: _____

My current home address is: _____

STATE OF SOUTH DAKOTA)
) SS
 COUNTY OF _____)

On this the _____ day of _____, before me, _____,
 (Month and Year)

the undersigned officer, personally appeared _____, known to me or
 satisfactorily proven to be the person whose name is subscribed to the within instrument and acknowledged
 that he/she executed the same for the purposes therein contained.

In witness whereof I have hereunto set my hand and official seal.

 Notary Public

(S E A L)

My commission expires: