POWER OF ATTORNEY, GUARDIANSHIP, DO-NOT-RESUSCITATE AND ADVANCED DIRECTIVES

PRESENTED BY:

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ATTORNEYS

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OKLAHOMA STATUTORY POWER OF ATTORNEY FORM

STATUTORY POWER OF ATTORNEY FORM

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

I _____ (insert your name and address) appoint _____ (insert the name and address of the person appointed) as my agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects:

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (N) AND IGNORE THE LINES IN FRONT OF THE OTHER POWERS.

TO GRANT ONE OR MORE, BUT FEWER THAN ALL, OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF EACH POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF IT. YOU MAY, BUT NEED NOT, CROSS OUT EACH POWER WITHHELD.

INITIAL

_____ (A) Real property transactions.

_____ (B) Tangible personal property transactions.

_____ (C) Stock and bond transactions.

_____ (D) Commodity and option transactions.

_____ (E) Banking and other financial institution transactions.

_____ (F) Business operating transactions.

_____ (G) Insurance and annuity transactions.

_____ (H) Estate, trust, and other beneficiary transactions.

_____ (I) Claims and litigation.

_____ (J) Personal and family maintenance.

_____ (K) Benefits from Social Security, Medicare, Medicaid, or other governmental programs, or military service.

_____ (L) Retirement plan transactions.

_____ (M) Tax matters.

_____ (N) ALL OF THE POWERS LISTED ABOVE. YOU NEED NOT INITIAL ANY OTHER LINES IF YOU INITIAL LINE (N).

SPECIAL INSTRUCTIONS:

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Attach additional pages if needed.)

UNLESS YOU DIRECT OTHERWISE ABOVE, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

This power of attorney will continue to be effective even though I become disabled, incapacitated, or incompetent.

STRIKE THE PRECEDING SENTENCE IF YOU DO NOT WANT THIS POWER OF ATTORNEY TO CONTINUE IF YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed this _____ day of _____, 19___

_____
(Your Signature)

_____
(Your Social Security Number)

State of _____

(County) of_____

This document was acknowledged before me on

_____(Date)

by_____
(Name of principal)

_____
(Signature of notarial officer)

(Seal, if any)

_____
(Title and Rank)

My commission expires: _____

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

DURABLE POWER OF ATTORNEY

Durable Power of Attorney

A durable power of attorney is a power of attorney by which a principal designates another his attorney-in-fact in writing and the writing contains the words "*This power of attorney shall not be affected by subsequent disability, incapacity, or extended absence of the principal, or lapse of time*", or "*This power of attorney shall become effective upon the disability, incapacity, or extended absence of the principal*", or similar words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding the principal's subsequent disability, incapacity, or extended absence, and, unless it states a time of termination, notwithstanding the lapse of time since the execution of the instrument.

The power may grant complete or limited authority with respect to the principal's:

1. Person, including, but not limited to, health and medical care decisions and a do-not-resuscitate consent on the principal's behalf, but excluding:

> *a. the execution, on behalf of the principal, of a Directive to Physicians, an Advance Directive for Health Care, Living Will, or other document, except an Oklahoma standardized format physician orders for life-sustaining treatment form in accordance with the provisions of this act, purporting to authorize life-sustaining treatment decisions, and*
>
> *b. the making of life-sustaining treatment decisions unless the power complies with the requirements for a health care proxy under the Oklahoma Advance Directive Act or the Oklahoma Do-Not-Resuscitate Act;* and

2. Property, including homestead property, whether real, personal, intangible or mixed.

OKLAHOMA
DO-NOT-RESUSCITATE FORM

FRONT PAGE

OKLAHOMA DO-NOT-RESUSCITATE (DNR) CONSENT FORM

I, _____, request limited health care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

I understand that I may revoke this consent at any time in one of the following ways:

1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

2. If I am not under the care of a health care agency, by destroying my do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation;

3. If I am incapacitated and under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by written notification to a physician or other health care provider of the health care agency or by oral notification to my attending physician; or

4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by destroying the do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a do-not-resuscitate order.

_____OR _____

Signature of Person

Signature of Representative

(Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Advance Directive Act or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.)

This DNR consent form was signed in my presence.

_____	_____	_____
Date	Signature of Witness	Address
	_____	_____
	Signature of Witness	Address

BACK OF PAGE

CERTIFICATION OF PHYSICIAN

(**This form is to be used by an attending physician only to certify that an incapacitated person without a representative would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest.** An attending physician of an incapacitated person without a representative must know by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that such person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Clear and convincing evidence for this purpose shall include oral, written, or other acts of communication between the patient, when competent, and family members, health care providers, or others close to the patient with knowledge of the patient's desires.)

I hereby certify, based on clear and convincing evidence presented to me, that I believe that would not have consented to the Name of Incapacitated Person adminstration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Therefore, in the event of cardiac or respiratory arrest, no chest compressions, artificial ventilation, intubations, defibrillation, or emergency cardiac medications are to be initiated.

_____ _____

Physician's Signature/Date Physician's Name (PRINT)

_____

Physician's Address/Phone

OKLAHOMA ADVANCED DIRECTIVE FORM

Advance Directive for Health Care

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

I. Living Will

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

(1) If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

(Initial only one option)

____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ See my more specific instructions in paragraph (4) below. (Initial if applicable)

(2) If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(Initial only one option)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ See my more specific instructions in paragraph (4) below. (Initial if applicable)

(3) If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

(Initial only one option)

_____ I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____ I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ See my more specific instructions in paragraph (4) below. (Initial if applicable)

(4) OTHER. Here you may:

(a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn,

(b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition, or

(c) do both of these:

_____

_____

_____

_____

_____

_____

_____ (Initial)

II. My Appointment of My Health Care Proxy

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Advance Directive Act to follow the instructions of _____, whom I appoint as my health care proxy. If my health care proxy is unable or unwilling to serve, I appoint _____ as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

III. Anatomical Gifts

Pursuant to the provisions of the Uniform Anatomical Gift Act, I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of:

(Initial all that apply)

_____ transplantation

_____ therapy

_____ advancement of medical science, research, or education

_____ advancement of dental science, research, or education

Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. If I initial the "yes" line below, I specifically donate:

_____ My entire body

or

_____ The following body organs or parts:

_____ lungs	_____ liver
_____ pancreas	_____ heart
_____ kidneys	_____ brain
_____ skin	_____ bones/marrow
_____ blood/fluids	_____ tissue
_____ arteries	_____ eyes/cornea/lens

IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to execute this form.

b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.

c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.

d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.

e. This advance directive shall be in effect until it is revoked.

f. I understand that I may revoke this advance directive at any time.

g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.

h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

Signed this _____ day of _____, 20 __.

_____

Signature

_____

City of

_____

County, Oklahoma

_____

Date of birth

_____

(Optional for identification purposes)

This advance directive was signed in my presence.

_____

Witness

_____, Oklahoma

Residence

_____

Witness

_____, Oklahoma

Residence