[The following sections appear if you choose to include your wishes for health care and medical decisions if you are incapacitated and unable to make them yourself.]

STATE OF SOUTH CAROLINA
COUNTY OF [COUNTY]

DECLARATION OF A DESIRE FOR A NATURAL DEATH

I, Jane Doe, Declarant, being at least eighteen years of age and a resident of and domiciled in the City of [CITY], County of [COUNTY], State of South Carolina, make this Declaration this ___ day of _____, 20___.

[This section will appear if you elect to be kept on life support.]

I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

[This section will appear if you elect to not be kept on life support and will vary depending on your choices.]

I willfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of permanent unconsciousness, and I declare:

If at any time I have a condition certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

If I am pregnant, unless live birth is unlikely to a reasonable degree of medical certainty and that fact is known to my physician, this section will have no force or effect during that pregnancy.

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I. INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION

[The following paragraphs will appear if you elect to not be kept on life support and will vary depending on your choices regarding nutrition and hydration.]

If my condition is terminal and could result in death within a reasonably short time, I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

If I am in a persistent vegetative state or other condition of permanent unconsciousness, I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

I desire to receive treatment for comfort or to alleviate pain except as stated: If it is additive.

[This section will appear if you write additional health care instructions.]

I further direct that: Please make sure that I will not feel any pain.

[The following paragraphs will appear if you elect to not be kept on life support.]

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.

II. GENERAL PROVISIONS

If any provision hereof is held to be invalid, such invalidity shall not affect the other provisions of this document, and such other provisions shall be given effect without the invalid provision.

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It is my intent that this document be legally binding and effective. If the law does not recognize the legal validity of this document, it is my intention that this document be taken as a formal declaration of my intentions concerning all of the above provisions. Copies of this document have the same effect as the original.

All persons or entities that in good faith endeavor to carry out the provisions of this document shall not be liable to me, my estate, or my heirs, for any damages or claims arising because of their actions or inactions based on this document. My estate shall indemnify and hold them harmless

III. NOTICE REGARDING REVOCATION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN.

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF YOUR INTENT TO REVOKE, BY YOU OR BY SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE ORIGINAL DECLARATIONS REVOKES ALL OF THE ORIGINAL DECLARATIONS;

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE;

(3) BY YOUR ORAL EXPRESSION OF YOUR INTENT TO REVOKE THE DECLARATION. AN ORAL REVOCATION COMMUNICATED TO THE ATTENDING PHYSICIAN BY A PERSON OTHER THAN YOU IS EFFECTIVE ONLY IF:

(a) THE PERSON WAS PRESENT WHEN THE ORAL REVOCATION WAS MADE;

(b) THE REVOCATION WAS COMMUNICATED TO THE PHYSICIAN WITHIN A REASONABLE TIME;

(c) YOUR PHYSICAL OR MENTAL CONDITION MAKES IT IMPOSSIBLE FOR THE PHYSICIAN TO CONFIRM THROUGH SUBSEQUENT CONVERSATION WITH YOU THAT THE REVOCATION HAS OCCURRED.

TO BE EFFECTIVE AS A REVOCATION, THE ORAL EXPRESSION CLEARLY MUST

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INDICATE YOUR DESIRE THAT THE DECLARATION NOT BE GIVEN EFFECT OR THAT LIFE-SUSTAINING PROCEDURES BE ADMINISTERED; OR

(4) BY YOUR EXECUTING ANOTHER DECLARATION AT A LATER TIME.

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IN WITNESS WHEREOF, I have signed this Declaration on the date first stated above.

_____
Signature of Jane Doe

Dated: _____, 20___

100 Main Street
[CITY], South Carolina [ZIP]

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AFFIDAVIT

STATE OF SOUTH CAROLINA

COUNTY OF _____

We, _____ and _____, the undersigned witnesses to the foregoing Declaration, dated the _____ day of _____, 20____, at least one of us being first duly sworn, declare to the undersigned authority, on the basis of our best information and belief, that the Declaration was on that date signed by the declarant as and for his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence and we, at his request and in his presence, and in the presence of each other, subscribe our names as witnesses on that date. The declarant is personally known to us, and we believe him to be of sound mind. Each of us affirms that he is qualified as a witness to this Declaration under the provisions of the South Carolina Death With Dignity Act in that he is not related to the declarant by blood, marriage, or adoption, either as a spouse, lineal ancestor, descendant of the parents of the declarant, or spouse of any of them; nor directly financially responsible for the declarant's medical care; nor entitled to any portion of the declarant's estate upon his decease, whether under any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the declarant; nor the declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the declarant is a patient. If the declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

_____
Signature of witness

_____
Signature of witness

Subscribed before me by Jane Doe, the declarant, and subscribed and sworn to before me by _____ and _____, the witnesses, this _____ day of _____, 20___.

_____
Signature of Notary

Notary Public for _____
My commission expires: _____
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[This page varies depending upon your choices regarding organ donation.]

ANATOMICAL GIFTS

I, Jane Doe, hereby authorize the making of anatomical gifts of the following parts of my body for the following purposes:

Gift:	All organs and part.
Purpose:	Medical purposes only, education, and research.

IN WITNESS WHEREOF, I have signed this document on the date written below.

Date: _____

_____
Signature of Jane Doe

Witness Declarations: We hereby declare that we are not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them and we are signing at the direction of the principal.

Signature:_____

Print Name:_____

Signature:_____

Print Name:_____

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[The following sections appear if you choose to appoint someone to make health care decisions for you if you are unable to make them yourself.]

SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.

2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.

3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.

5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

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6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

A. YOUR SPOUSE, YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

D. A BENEFICIARY OF A LIFE INSURANCE POLICY ON YOUR LIFE.

E. THE PERSONS NAMED IN THE HEALTH CARE POWER OF ATTORNEY AS YOUR AGENT OR SUCCESSOR AGENT.

F. YOUR PHYSICIAN OR AN EMPLOYEE OF YOUR PHYSICIAN.

G. ANY PERSON WHO WOULD HAVE A CLAIM AGAINST ANY PORTION OF YOUR ESTATE (PERSONS TO WHOM YOU OWE MONEY).

IF YOU ARE A PATIENT IN A HEALTH FACILITY, NO MORE THAN ONE WITNESS MAY BE AN EMPLOYEE OF THAT FACILITY.

7. YOUR AGENT MUST BE A PERSON WHO IS 18 YEARS OLD OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

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8. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

I. DESIGNATION OF HEALTH CARE AGENT

I, Jane Doe, hereby appoint:

Name: John Doe
Relation: Husband
Address: 100 Main Street
[CITY], South Carolina [ZIP]
Phone: (800) 555-1234
Alt. Phone: (888) 123-5555
Email: jdoe@legalzoomsample.com

as my agent to make health care decisions for me as authorized in this document.

[This section appears if you choose to appoint an alternate agent.]

Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, or becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following person as successor to my agent:

Alternate Agent:

Name: Ann Doe
Relation: Daughter
Address: 100 Main Street
[CITY], South Carolina [ZIP]
Phone: (800) 555-1234
Alt. Phone: (888) 123-5555
Email: adoe@legalzoomsample.com

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Unavailability of Agent: If at any relevant time the agent or successor agent named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the probate court, or by a surrogate pursuant to the South Carolina Adult Health Care Consent Act, it is my intention that the guardian, probate court, or surrogate make those decisions in accordance with my directions as stated in this document.

II. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective on, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

III. HIPAA AUTHORIZATION

When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to: (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse; and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and will terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

IV. AGENT'S 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 expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to de-

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termine 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 the provisions specified 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, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation.

   I do not authorize my agent to direct the disposition of my remains.

   I do not authorize my agent to consent to an autopsy of my remains.

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain except as follows: If it is addictive.

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service.

D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, 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.

[The following section appears if you place limitations on your agent's authority.]

E. The powers granted above do not include the following powers or are subject to the following rules or limitations: I do not wish my agent to decide which organs to donate. I want as many as possible to be donated.

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F. No person who may act in reliance upon the representations of my attorney-in-fact for the scope of authority granted to the attorney-in-fact shall incur any liability as to me or to my estate as a result of permitting the attorney-in-fact to exercise this authority, nor is any such person who deals with my attorney-in-fact responsible to determine or ensure to proper application of funds or property.

G. All persons or entities that in good faith endeavor to carry out the provisions of this document shall not be liable to me, my estate, or my heirs, for any damages or claims arising because of their actions or inactions based on this document. My estate will indemnify and hold them harmless.

V. ORGAN DONATION

My agent may not consent to the donation of all or any of my tissue or organs for purposes of transplantation.

VI. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

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VII. STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING TREATMENT

With respect to any life-sustaining treatment, I direct the following:

[The following paragraphs will appear if you choose in the questionnaire to specify your wishes for health care and medical decisions if you are incapacitated and if you elect to not be kept on life support. The paragraphs will vary depending on your choices.]

A. DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment: If I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time or If I am in a state of permanent unconsciousness.

B. DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

[The following paragraphs will appear if you do not choose in the questionnaire to specify your wishes for health care and medical decisions if you are incapacitated and unable to make them yourself.]

(initial)_____ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or

b. if I am in a state of permanent unconsciousness.

OR

(initial)_____ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the

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chances I have for recovery, or the cost of the procedures.

VIII. STATEMENT OF DESIRES REGARDING TUBE FEEDING

[This section will appear if you choose to include your wishes for health care and medical decisions. This section will vary depending on your choices regarding artificial food and water.]

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 in situations where life-sustaining treatment is being withheld or withdrawn pursuant to Paragraph 7: DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

[This section will appear if you choose not to include your wishes for health care and medical decisions.]

(initial) _____ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding.

(initial) _____ DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

IX. ADMINISTRATIVE PROVISIONS

A. I revoke any prior health care powers of attorney and any provisions relating to health care of any other prior powers of attorney.

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

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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 Health Care Power of Attorney on this ___ day of _____, 20 __. My current home address is: 100 Main Street, [CITY], South Carolina [ZIP].

Principal's Signature: _____

Print Name of Principal: Jane Doe

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WITNESS STATEMENT

Each of the undersigned declares as follows: on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as health care agent or successor health care agent by this document.

Witness No. 1

Signature:_____ Date: _____

Print Name:_____ Telephone: _____

Address: _____

Witness No. 2

Signature:_____ Date: _____

Print Name:_____ Telephone: _____

Address: _____

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