WISCONSIN HEALTH CARE DIRECTIVE

(LIVING WILL / HEALTH CARE POWER OF ATTORNEY)

OF

John Doe

NOTICE TO PERSON MAKING THIS DOCUMENT

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKE ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY
SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKED, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE OR DOMESTIC PARTNER AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED OR THE DOMESTIC PARTNERSHIP IS TERMINATED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.
DECLARATION TO PHYSICIANS

[This section will appear if you select living will and will vary depending on your choices in regards to life support.]

LIVING WILL

I, John Doe, being of sound mind, do hereby make and declare this to be my health care directive, thereby revoking and making null and void any and all other health care directives and living wills previously made by me.

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

I voluntarily state my desire to prolong my life as long as reasonably possible within the limits of generally accepted health care standards.

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

I voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a TERMINAL CONDITION, as determined by 2 physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes: I want feeding tubes used if I have a terminal condition.

2. If I am in a PERSISTENT VEGETATIVE STATE, as determined by 2 physicians who have personally examined me, I do not want life-sustaining procedures used if I am in a persistent vegetative state. In addition, the following are my directions regarding the use of feeding tubes: I want feeding tubes used if I am in a persistent vegetative state.

I want to receive as much medication as is necessary to alleviate my pain, except: This section is reserved for any restrictions you place on the use of pain medication.
[This section will appear if you write additional health care instructions.]

I further direct that: This section is reserved for any additional health care instructions you provide.

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.

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.
IN WITNESS WHEREOF, I have executed this document on the date below:

____________________________________
Signature of John Doe

Dated: _______________________, 20__

123 Main Street
Appleton, Wisconsin 54911

WITNESS DECLARATIONS

Each of the undersigned states as follows: I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage, or adoption. I am not entitled to and do not have a claim on any portion of the person’s estate and am not otherwise restricted by law from being a witness.

Date: ________________________________
Signature: ____________________________
Print Name: __________________________
Address: ______________________________

Date: ________________________________
Signature: ____________________________
Print Name: __________________________
Address: ______________________________
DIRECTIVES TO ATTENDING PHYSICIAN

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when 2 physicians, one of whom is the attending physician, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

2. The choices in this document were made by a competent adult. Under the law, the patient’s stated desires must be followed unless you believe that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient’s stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed.

3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.
[This section varies depending upon your choices regarding organ donation.]

ANATOMICAL GIFTS

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

Gift: All organs and parts.
Purpose: Medical purposes and anatomical study.

____________________________________
Signature of John Doe

Dated: _______________________, 20___

123 Main Street
Appleton, Wisconsin 54911
POWER OF ATTORNEY FOR HEALTH CARE

Document made this____ day of ______________, 20____.

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, John Doe who reside at 123 Main Street, Appleton, Wisconsin 54911 born on 01/01/1959, being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, “health care decision” means an informed decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose, or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate:

Name: Jane Doe
Relation: Spouse
Address: 123 Main Street
          Appleton, Wisconsin 54911
Phone: (323) 962-8600
Alt. Phone: (323) 962-8600
Email: jane@legalzoom.com

to be my health care agent for the purpose of making health care decisions on my behalf.

If he or she is ever unable or unwilling to do so, I hereby designate:
Name: Amber Doe  
Relation: Daughter  
Address: 123 Main Street  
           Appleton, Wisconsin 54911  
Phone: (323) 962-8600  
Alt. Phone: (323) 962-8600  
Email: amber@legalzoom.com

to be my alternate health care agent for the purpose of making health care decisions on my behalf.

Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient, or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, “incapacity” exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

**GENERAL STATEMENT OF AUTHORITY GRANTED**

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.
[This section appears if you choose to give your agent control over what to do with your remains and varies based upon your choices]

I authorize my agent to direct the disposition of my remains. It is my desire that my remains be interred in a burial plot. I further direct: This section is reserved for any instructions you provide regarding the disposition of your remains.

I authorize my agent to consent to an autopsy of my remains.

**LIMITATIONS ON MENTAL HEALTH TREATMENT**

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with mental retardation, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

**PROVISION OF FEEDING TUBE**

If I have checked “Yes” to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked “No” to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube: ____ YES  ____ NO

If I have not checked either “Yes” or “No” immediately above, my health care agent may not have a feeding tube withdrawn from me.

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

**STATEMENT OF LIMITATIONS**

In exercising authority under this document, my health care agent’s authority shall be limited as follows: This section is reserved for any limitations that you place on your agent’s
INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

(a) Request, review, and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records.

(b) Execute on my behalf any documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

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.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and any similar state laws, and exclusively for the purpose of making a determination of my incapacitation or inability to direct my own health care decisions and obtaining a physician affidavit of such, I authorize any health care provider to disclose to the person named herein as my health care agent or alternate health care agent, as applicable, any pertinent individually identifiable health information sufficient to determine whether I am by reason of illness or mental or physical disability incapacitated or incapable of directing my own health care decisions. In exercising such authority, my health care agent shall constitute my “personal representative” as defined by HIPAA.

Upon the determination of my incapacitation or incapability to direct my own health care decisions, I intend for the person named herein as my health care agent or alternate health care agent, as applicable, to be treated as my “personal representative” under HIPAA and any similar state laws, and as such to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records.
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.
SIGNATURE OF PRINCIPAL

IN WITNESS WHEREOF, I have executed this document on the date below:

____________________________________
Signature of John Doe

Dated: _____________________________, 20___

123 Main Street
Appleton, Wisconsin 54911
STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, domestic partnership, or adoption, and am not directly financially responsible for the principal’s health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the declarant is a patient. I am not the principal’s health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal’s estate.

Date: ________________________________
Signature: ____________________________
Print Name: __________________________
Address: ______________________________________________________________________

Date: ________________________________
Signature: ____________________________
Print Name: __________________________
Address: ______________________________________________________________________
STATEMENT OF HEALTH CARE AGENT

I understand that John Doe has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself. John Doe has discussed his or her desires regarding health care decisions with me.

____________________________________
Signature of Jane Doe

Dated: _______________________, 20__

123 Main Street
Appleton, Wisconsin 54911

____________________________________
Signature of Amber Doe

Dated: _______________________, 20__

123 Main Street
Appleton, Wisconsin 54911

This power of attorney for health care is executed as provided in chapter 155 of the Wisconsin Statutes.
These are sample documents for the State of Wisconsin. Actual content differs by state and may vary based on your answers to the LegalZoom questionnaire.

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