The Rest Of Your Life www.theroyl.com

Advance Directive and Durable Power of Attorney

Advance Directive for Medical / Surgical Treatment (Living Will) and Medical Durable Power of Attorney for Healthcare Decisions

State of Colorado

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

Advance Directives Electronic Forms

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

Why do an Advance Directive?

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

Description:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

Security:

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).

ADVANCE DIRECTIVE FOR MEDICAL / SURGICAL TREATMENT
(Living Will)

On completion, give copies to your physician, family members, and Healthcare Agent. If you wish to revoke or replace this document, mark it clearly as "Revoked" or destroy it and all its copies, if possible. If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.

I. DECLARATION

I, EXAMPLE, am at least eighteen years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

A. Terminal Condition

If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

1. Life-Sustaining Procedures **(*initial one*):**

_____(*Initials*) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____(*Initials*) I direct that life-sustaining procedures shall be continued for/until (*state timeframe or goal)*:

_____

2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken **(*initial one*)**:

_____(*Initials*) Artificial nutrition and hydration shall not be continued.

_____(*Initials*) Artificial nutrition and hydration shall be continued for/until (*state timeframe or goal*):

_____

_____(*Initials*) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

B. Persistent Vegetative State

If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

1. Life-Sustaining Procedures **(*initial one*):**

_____(*Initials*) I direct that life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____(*Initials*) I direct that life-sustaining procedures shall be continued for/until (*state timeframe or goal)*:

_____

2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken **(*initial one*)**:

_____(*Initials*) Artificial nutrition and hydration shall not be continued.

_____(*Initials*) Artificial nutrition and hydration shall be continued for/until (*state timeframe or goal*):

_____

_____(*Initials*) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

II. OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care after you are certified in a terminal condition or Persistent Vegetative State (*for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments such as dialysis, transfusions, antibiotics, diagnostic tests, etc.*) **(*initial one*)**:

_____(*Initials*) Yes, I have attached other directions.

_____(*Initials*) No, I do not have any other directions.

III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY **(*initial one*)**

_____(*Initials*) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

_____(*Initials*) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that these persons are not empowered to make any decisions regarding my care, unless I have appointed them as my Healthcare Agents under Medical Durable Power of Attorney.

Name *Relationship*

V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawal life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

Name *Telephone number or email*

VI. ANATOMICAL GIFTS

_____(*Initials*) I wish to donate my (*check one or both*) _____organs and/or_____tissues, if medically possible.

_____(*Initials*) I do not wish donate my organs or tissues.

VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this_____day of_____, 20___.

Declarant signature

VIII. DECLARATION OF WITNESSES

This declaration was signed by (*name of Declarant*)
EXAMPLE
in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We declare that, at the time the Declarant signed this declaration, we believe that he or she was of sound mind and under no pressure or undue influence. We did not sign the Declarant's signature. We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient. We are neither creditors nor heirs of the Declarant and have no claim against any portion of the Declarant's estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

Signature of Witness

Printed Name

Address

Signature of Witness

Printed Name

Address

Notary Seal (optional)

State of _____
County of_____}

SUBSCRIBED and sworn to before me by

_____, the Declarant,

and _____

and _____

witnesses, as the voluntary act and deed of the Declarant

this day of_____, 20____.

Notary Public
My commission expires:_____

MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

I. APPOINTMENT OF AGENT AND ALTERNATES

I, EXAMPLE,
Declarant, hereby appoint:

_____
Name of Agent

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

_____
Name of Alternate Agent #1

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

_____
Name of Alternate Agent #2

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

II. WHEN AGENT'S POWERS BEGIN

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either ***(initial one)***:

_____(*Initials*) Immediately upon my signature.

_____(*Initials*) When my physician or other qualified medical professional has determined that I am unable to make my or express my own decisions, and for as long as I am unable to make or express my own decisions.

III. INSTRUCTIONS TO AGENT

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

My signature below indicates that I understand the purpose and effect of this document:

_____
Signature of Declarant *Date*

ADDENDUM TO MEDICAL DURABLE POWER OF ATTORNEY – *RECOMMENDED, NOT REQUIRED*

1. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (*name of Declarant*)

EXAMPLE

_____.

I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

_____
Primary Agent's Signature

_____
Printed Name

_____
Date

_____
Alternate Agent #1 Signature

_____
Printed Name

_____
Date

_____
Alternate Agent #2 Signature

_____
Printed Name

_____
Date

2. Signature of Witnesses and Notary

The signature of two witnesses and a notary seal are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by (*name of Declarant*)

EXAMPLE

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We declare that, at the time the Declarant signed this document, we believe that he or she was of sound mind and under no pressure or undue influence. We are at least eighteen (18) years old.

_____
Signature of Witness

_____
Printed Name

_____
Address

_____

_____
Signature of Witness

_____
Printed Name

_____
Address

_____

Notary Seal (optional)

State of _____
County of_____}
SUBSCRIBED and sworn to before me by

_____, the Declarant,

and _____

and _____

witnesses, as the voluntary act and deed of the Declarant this day of_____, 20____.

_____
Notary Public
My commission expires:_____