The Rest Of Your Life www.theroyl.com

Advance Directive and Durable Power of Attorney

Living Will Declaration and Durable Power of Attorney for Healthcare Decisions

State of Kansas

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).

LIVING WILL DECLARATION

I, EXAMPLE, being of sound mind, willfully and voluntarily making known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such 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 deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this decision.

Declarations made this _____(day) of _____(month, year)

Signature:

X _____

Address: _____

street **city** **state** **zip**

This document must be witnessed by two individuals *or* acknowledged by a notary public.

Notary Public: Notary Seal:

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me this _____ day of _____(month, year)

Signature of Notary _____

My appointment expires: _____

or

Witnesses:

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly responsible for declarant's medical care.

Name: _____ Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

This document is based on Kansas Statute 65-28,101 et seq. as amended
Copy protected. Additional forms and information are available through
Kansas Health Ethics, Inc., 5900 East Central Ave., Suite 101, Wichita, KS 67208.
Telephone (316) 684-1991
www.kansashealthethics.org

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

DECISION TO NAME SOMEONE TO SPEAK FOR ME

I, (your name) EXAMPLE _____, appoint the following person(s) to make healthcare decisions for me when I am unable to make or communicate my own wishes:

Agent may not be the treating healthcare provider, an employee of the treating healthcare provider, or an employee, owner, director or officer of a facility, unless that person is a relative or is bound to you by common vows to a religious life.

PLEASE PRINT:

Name of Agent: _____ Telephone _____ _____
(Day) (Evening)
Agent's address: _____ City _____ State/Zip _____

Name of First Alternate Agent: _____ Telephone _____ _____
(Day) (Evening)
Agent's address: _____ City _____ State/Zip _____

Name of Second Alternate Agent: _____ Telephone _____ _____
(Day) (Evening)
Agent's address: _____ City _____ State/Zip _____

This power of attorney for healthcare decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

AUTHORITY GRANTED

My healthcare agent may:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition;
2. Make all arrangements for me at any hospital, treatment facility, hospice, nursing home or similar institution;
3. Employ or discharge healthcare personnel including physicians, psychiatrists, dentists, nurses, therapists or other persons who provide treatment for me;
4. Request, receive and review any information, spoken or written, regarding my personal affairs or physical or mental health including medical and hospital records, and execute any releases or other documents that may be required in order to obtain such information; and
5. Make decisions about organ and tissue donations, autopsy and the disposition of my body.

My agent shall authorize consent for the following special instructions:

- ■ I wish to be a donor for organs and tissues.
- ■ I have attached information about treatment choices I wish to have honored by my agent.

LIMITATIONS ON AUTHORITY GRANTED

My healthcare agent may not:

1. Exceed the powers set out in writing in this document; *or*
2. Revoke any existing Living Will Declaration I may have.
   - ■ I have attached information about special limitations I wish to have honored by my agent.

X _____
signature date

Notary Public: Notary Seal:

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me this _____ day of _____ (month, year)

Signature of Notary _____

My appointment expires: _____

or

Witnesses: (witnesses may not be the agent or a relative, or beneficiary of the principal)

X _____ Date: _____
(Signature)

X _____ Date: _____
(Signature)

This document is based on Kansas Statutes Annotated, (58-625 through 632)
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