

**COLORADO MEDICAL DURABLE
POWER OF ATTORNEY
FOR HEALTH CARE**

I, _____, hereby appoint: _____
(name) *(name of agent)*

(home address of agent)

(work telephone number of agent) _____
(home telephone number of agent)

as my agent to make health care decisions for me if and when I am unable to make my own health care decisions. This gives my agent the power to consent to giving, withholding or stopping any health care, treatment, service or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information and sign forms necessary to carry out those decisions.

If the person named as my agent is not available or is unable or unwilling to act as my agent, then I appoint the following person(s) to serve in the order listed below:

1. _____
(name of first alternate)

(home address)

(work telephone number) _____
(home telephone number)

2. _____
(name of first alternate)

(home address)

(work telephone number) _____
(home telephone number)

By this document I intend to create a Medical Durable Power of Attorney, which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity. My agent shall make health care decisions as I may direct below or as I make known to him or her in some other way. If I have not expresses a choice

about the health care in question, my agent shall base his/her decisions on what he/she believes to be in my best interests.

(A) Statement of desires concerning life-prolonging care, treatment, services and procedures:

(B) Special provisions and limitations:

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

I sign my name to this form on: _____
(date)

(Signature of Declarant)

(Address)

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that he/she signed or acknowledge this Medical Durable Power of Attorney in my presence, and that she/she appears to be of sound mind and under no duress, fraud or undue influence. **I am not the person appointed as the agent by this document, nor am I the patient's health care provider, or an employee of the patient's health care provider.**

(First Witness' Signature)

(Second Witness's Signature)

(Home Address)

(Home Address)

(Print Name)

(Print Name)

(Date)

(Date)