ADVANCE DIRECTIVE
and
MEDICAL POWER OF ATTORNEY

I. ADVANCE DIRECTIVE

This is an important legal document known as an advance directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill. You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care providers, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

A. LIFE-PROLONGING PROCEDURES.

If at any time I am BOTH mentally and physically incapacitated AND
_____ (initial) I have a terminal condition
_____ (initial) or I have an irreversible condition

AND if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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 or to alleviate pain.

B. NUTRITION AND HYDRATION. If I have a condition stated above, it is my preference TO RECEIVE artificially administered nutrition and hydration (food and fluids).

C. ORGAN DONATION. In the event of my death, I donate the following part(s):

Organs or Tissues: _____

Limitations: _____

D. CONSULT. I hereby request that the following individuals be notified and given an opportunity to consult with my physician(s) prior to the withholding of any life-sustaining treatment. This request does not provide the named individuals with authority to override the decision of my physicians, only the opportunity to offer their opinions and input regarding my condition and circumstances:

Name: _____
Address: _____
City: _____
State: _____
ZIP Code: _____
Phone Number: _____

DEFINITIONS:

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:
(1) that may be treated, but is never cured or eliminated;
(2) that leaves a person unable to care for or make decisions for the person's own self; AND
(3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal. Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care. Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important

persons in your life.

INFORMATION CONCERNING THE MEDICAL POWER OF ATTORNEY

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

Except to the extent you state otherwise, this document gives the person you name as your Agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition, your Agent has the power to make a broad range of health care decisions for you. Your Agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your Agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your Agent's instructions or allow you to be transferred to another physician.

Your Agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your Agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your Agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as Agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your Agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your Health Care Agent. You should discuss this document with your Agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your Agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for

yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your Agent by informing your Agent or your health or residential care provider orally or in writing, or by your execution of a subsequent Medical Power of Attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an Alternate Agent in the event that your Agent is unwilling, unable, or ineligible to act as your Agent. Any Alternate Agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES.

(1) the person you have designated as your Agent;
(2) a person related to you by blood or marriage;
(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
(4) your attending physician;
(5) an employee of your attending physician;
(6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner or business office employee of the health care facility or of any parent organization of the health care facility; or
(7) a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

NOTE: While Texas law requires that you be provided the disclosure statement substantially in the form which appears above, Section 166.154 of the Texas Health and Safety Code was amended in 2009 so that, in lieu of signing in the presence of the witnesses, the principal may sign the medical power of attorney on or after September 1, 2009, and have the signature acknowledged before a notary public.

II. MEDICAL POWER OF ATTORNEY

A. DESIGNATION OF AGENT. In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my Agent for health care decisions:

AGENT

Name: _____

Address: _____
_____, Texas

B. AUTHORITY OF AGENT. I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; to have access to my records necessary to make decisions or apply for benefits; and to authorize my admission to or transfer from a health care facility. I specifically give my Agent the authority to provide, withhold or withdraw consent to the provision of life-prolonging procedures on my behalf including the provision of artificially provided nutrition and hydration. My Agent must act consistently with my desires as stated in this document or otherwise made known.

C. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE. My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial the following line:

_____ (initial) my agent's authority to make health care decisions for me takes effect immediately.

D. NOMINATION OF GUARDIAN OR CONSERVATOR. If a guardian or conservator of my person or estate or both, needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian or conservator, I nominate the alternate agents whom I have named, in the order designated.

E. DESIGNATION OF ALTERNATE AGENT. If my Agent is unwilling or unable to perform his/her duties, I wish to designate as my Alternate Agent:

ALTERNATE AGENT

Name: _____

Address: _____
_____, _____

III. GENERAL PROVISIONS

A. HOLD HARMLESS. All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend and indemnify them.

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

end the directions in this document are severable.

C. STATEMENT OF INTENTIONS. It is my intent that this document be legally binding and effective. If the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period in which I am unable to make such decisions.

I affirm that this Living Will and Designation is not being made as a condition of treatment or admission to a health care facility. I have read and understand the contents of this document and the effect of this grant of powers to my Agent. I am emotionally and mentally competent to make this declaration.

Signed on _____ day of _____, _____.

Signature: _____

Name: _____
Address: _____
_____ County
Texas

STATE OF TEXAS,
COUNTY OF _____, ss:

This document was acknowledged before me on _____ (date) by _____ (name of principal).

_____
(signature of notarial officer)

_____
(printed name)

My commission expires _____