

# Illinois Statutory Short Form POWER OF ATTORNEY FOR HEALTH CARE

(NOTICE: the purpose of this power of attorney is to give the person you designate (your "agent") broad powers to make health care decisions for you, including power to require, consent to or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to or discharge you from any hospital, home or other institution. This form does not impose a duty on your agent to exercise granted powers; but when powers are exercised, your agent will have to use due care to act for your benefit and in accordance with this form and keep a record of receipts, disbursements and significant actions taken as agent. A court can take away powers of your agent if it finds the agent is not acting properly. You may name successor agents under this form but not co-agents, and no health care provider may be named. Unless you expressly limit the duration of this power in the manner provided below, until you revoke this power or a court acting on your behalf terminates it, your agent may exercise the powers given here throughout your lifetime, even after you become disabled. The powers you give your agent, your right to revoke those powers and the penalties for violating the law are explained more fully in sections 4-5, 4-6, 4-9 and 4-10(b) of the Illinois "Powers of Attorney for Health Care Law" of which this form is a part. That law expressly permits the use of any different form of power of attorney you may desire. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.)

POWER OF ATTORNEY made this \_\_\_\_ day of (month) \_\_\_\_\_, 20\_\_.

1. I, (print name and address of principal) \_\_\_\_\_  
\_\_\_\_\_ hereby appoint: (print name and address of agent) \_\_\_\_\_

as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains. Effective upon my death, my agent has the full power to make an anatomical gift of the following (initial one):

Any organ: \_\_\_\_\_

Specific organs: \_\_\_\_\_

(The above grant of power is intended to be as broad as possible so that your agent will have authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as: your own



definition of when lifesustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.):

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(The subject of life-sustaining treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. If you agree with one of these statements, you may initial that statement; but **do not initial more than one**):

\_\_\_ (initial here) I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

\_\_\_ (initial here) I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

\_\_\_ (initial here) I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures.

(This power of attorney may be amended or revoked by you in the manner provided in section 4-6 of the Illinois "powers of attorney for health care law" (see the back of this form). Absent amendment or revocation, the authority granted in this power of attorney will become effective at the time this power is signed and will continue until your death, and beyond if anatomical gift, autopsy or disposition of remains is authorized, unless a limitation on the beginning date or duration is made by initialing and completing either or both of the following:)

3. \_\_\_ (initial here) This power of attorney shall become effective on \_\_\_\_\_

\_\_\_\_\_ (insert a future date or event during your lifetime, such as court determination of your disability, when you want this power to first take effect)

4. \_\_\_ (initial here) This power of attorney shall terminate on \_\_\_\_\_

\_\_\_\_\_ (insert a future date or event, such as court determination of your



disability, when you want this power to terminate prior to your death)

*(If you wish to name successor agents, insert the names and addresses of such successors in the following paragraph.)*

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent: (print name(s) and address(es) of agent(s))

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

*(If you wish to name your agent as guardian of your person, in the event a court decides that one should be appointed, you may, but are not required to, do so by retaining the following paragraph. The court will appoint your agent if the court finds that such appointment will serve your best interests and welfare. Strike out paragraph 6 if you do not want your agent to act as guardian.)*

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed: (Principal)\_\_\_\_\_

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

**Witness:** Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

*(You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.)*

Specimen signatures of agent (and successors)

I certify that the signatures of my agent (and successors) are correct.

(agent) \_\_\_\_\_

(principal) \_\_\_\_\_

(successor agent) \_\_\_\_\_

(principal) \_\_\_\_\_

(successor agent) \_\_\_\_\_

(principal) \_\_\_\_\_



# ILLINOIS LIVING WILL DECLARATION

Declaration made this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_

I, *(please print name)* \_\_\_\_\_, being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed. If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care. In the absence of my ability to give directions regarding the use of such death delaying procedures, **it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.**

Signed \_\_\_\_\_  
City, County and State of Residence \_\_\_\_\_

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness #1: Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Address: \_\_\_\_\_

Witness #2: Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Address: \_\_\_\_\_

