

LIVING WILL

And

DESIGNATION OF PATIENT ADVOCATE FOR CARE, CUSTODY AND MEDICAL TREATMENT DECISIONS

I designate _____ as my patient advocate (or if for any reason he or she shall not act, then I designate _____ as my alternate patient advocate) to make care, custody and medical treatment decisions for me in the event I become unable to participate in medical treatment decisions. This designation shall become effective when I am no longer able to participate in medical treatment decisions. My patient advocate shall have the authority to interpret my Living Will, and shall make decisions about my medical treatment as specified in my Living Will or, when my wishes are not clear, as my advocate believes to be in my best interest.

My patient advocate shall have access to any of my medical records. I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes. It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for honoring my wishes as expressed in this designation or for implementing the decisions of my patient advocate. I release and agree to hold harmless my advocate from any and all claims whatsoever arising from decisions made in good faith in the exercise of this designation.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I am of sound mind and sign this Living Will and Designation of Patient Advocate knowingly, voluntarily, and after careful deliberations on the date set forth below.

Signature

Date

Print Name

OPTIONAL

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment, which would allow me to die and I acknowledge such decisions could or would allow my death.

Sign here if you wish to give your patient advocate this additional authority

STATEMENT OF WITNESSES: This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

WITNESSES

Sign:

Print:

Date

Sign:

Print:

Date

NOTE: Witnesses shall not be the patient's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee, physician, patient advocate, an employee of a health facility treating the patient, or an employee of a home housing the patient.

ACCEPTANCE OF PATIENT ADVOCATE

I accept the designation as patient advocate for

(the "Patient") and agree to the following terms:

This designation shall not become effective unless the Patient is unable to participate in medical treatment or care decisions.

I may make a decision to withhold or withdraw treatment which would allow the Patient to die only if the Patient has expressed in a clear and convincing manner that I am authorized as a patient advocate to make such a decision, and that the Patient acknowledges that such a decision could or would allow the Patient's death. This designation cannot be used to withhold or withdraw treatment from a Patient who is pregnant that would result in the Patient's death.

I shall not receive compensation for my services, but I may be reimbursed for actual and necessary expenses incurred in the performance of my duties.

I shall act in accordance with the standards of care applicable to fiduciaries when acting for the Patient and shall act consistent with the Patient's best interests and the known desires of the Patient expressed or evidenced while the Patient was able to participate in medical and care decisions.

The Patient may revoke this designation at any time and in any manner sufficient to communicate an intent to revoke.

I may revoke my acceptance of this designation at any time and in any manner.

A Patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act. No. 368 of the Public Acts of 1978, being section 333.20201 of the Michigan Compiled Laws.

I may not delegate my powers without prior authorization by the Patient.

Patient Advocate Signature

Date

Paid for by:

Graziani Election Committee
12795 Eureka Rd., Southgate, MI 48195

Alternate Patient Advocate Signature

Date