

POWER OF ATTORNEY FOR HEALTH CARE

I, _____ (*print full name*), being of sound mind, do hereby designate _____ (*print full name*) as my agent with full power and authority to make health care decisions for me including, but not limited to, a Declaration Concerning Life-Sustaining Procedures in the event I am unable to or choose not to make these decisions for myself. This Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity or other condition that makes an express revocation of my agent impossible or impractical. I also grant my agent the authority to qualify me for all government entitlements including, but not limited to, Medicaid, Medicare, and Supplemental Social Security.

SIGNATURE

PRINT NAME

CITY, PARISH OF RESIDENCE

STATE OF RESIDENCE

The declarant has been personally known to me and I believe him or her to be of sound mind.

WITNESS 1 SIGNATURE

WITNESS 1 PRINT NAME

WITNESS 2 SIGNATURE

WITNESS 2 PRINT NAME

Notarization of this form is optional.

Sworn and subscribed before me,
this _____ day of _____, _____.

Notary Public

My commission expires _____