



MEMORIAL HOSPITAL

ADVANCE

DIRECTIVES

**Planning Ahead: How to Make  
Future Health Care Decisions NOW**



MEMORIAL  
HOSPITAL

4500 Memorial Drive Belleville, Illinois 62226  
(618) 233-7750

4500 MEMORIAL DRIVE  
BELLEVILLE, ILLINOIS 62226-5399  
(618) 233-7750  
FAX: (618) 257-5658  
WWW.MEMHOSP.COM

MARK J. TURNER, PRESIDENT



Dear Patient:

Re: Memorial's Advance Directives Policy

Consistent with federal requirements, we want you and your family to know about Memorial's policy to comply with statutes promoting patient self-determination in healthcare decisions. Memorial encourages use of Advance Directives to assist in honoring your treatment preferences in Advance Directives, so long as they are permitted by law.

Memorial recognizes your right to:

1. Make informed decisions about your health care.
2. Accept or refuse medical or surgical treatment, and make decisions regarding death-delaying or life-sustaining treatment, even if such refusal could hasten your death.
3. In certain circumstances, have your representatives make health care decisions for you if your condition prevents you from doing so.
4. Not be required to execute an Advance Directive, and not be discriminated against or have your care depend upon whether or not you have executed an Advance Directive.

This booklet contains important documents we encourage you and your family to review:

1. An overview from the Illinois Department of Public Health RE: Statement of Illinois Law on Advance Directives.
2. Questions and Answers on Illinois Living Wills and Powers of Attorney for Health Care.
3. Documents: "Living Will Declaration," and "Powers of Attorney for Health Care."

If you or your family have any questions about Memorial's Advance Directives policies, our nursing professionals can refer you to Memorial's personnel who can best assist you.

Sincerely,

*Nancy Weston RN, MSN*

Nancy Weston, RN, MSN  
Vice President, Nursing Services

# Illinois Department of Public Health Overview

## STATEMENT OF ILLINOIS LAW ON ADVANCE DIRECTIVES

You have the right to make decisions about the health care you receive now and in the future. An advance directive is a written statement about how you want medical decisions made when you can no longer make them. Federal law requires that you be told of your right to make an advance directive when you are admitted to a health care facility. Illinois has these advance directives: (1) health care power of attorney, (2) living will, and (3) mental health treatment preference declaration. If you make an advance directive, tell your doctor and other health care providers and provide them with a copy.

### Health Care Power of Attorney

The **health care power of attorney** lets you choose someone to make health care decisions for you if you cannot. You are called the “principal” in the power of attorney form and the person you choose is called your “agent.” You can use a standard form or write your own. You may give your agent specific directions about the health care you do or do not want.

The agent you choose cannot be your doctor or other health care provider. You should have someone who is not your agent witness your power of attorney. You can cancel your power of attorney by telling someone or by canceling it in writing. You can name a backup agent to act if the first one cannot or will not take action. If you want to change your power of attorney, you must do so in writing.

### Living Will

A **living will** lets you tell your doctor if you want death-delaying procedures used if you have a terminal condition and are unable to state your wishes. Withdrawal of food and water cannot be done if it would be the only cause of death. If you are pregnant and doctors feel you could have a live birth, your living will cannot go into effect.

You can use a standard living will form or write your own. You may write specific directions about death-delaying procedures you do or do not want. The living will must be witnessed by two people. Your doctor cannot be a witness. You must tell your doctor about the existence of a living will. You can cancel your living will by telling someone or by cancelling it in writing. If you have both a health care power of attorney and a living will, the agent you name in your power of attorney will make your health care decisions unless he or she is unavailable.

### Mental Health Treatment Preference Declaration

A **mental health treatment preference declaration** lets you say if you want to receive electroconvulsive treatment or psychotropic medicine when you have a mental illness. You also can say whether you wish to be admitted to a mental health facility for up to 17 days of treatment.

You can write your wishes or choose someone to make your mental health decisions for you. In a mental health treatment declaration, you may choose someone to make decisions about mental health treatment if you are incapable. In the declaration, you are called the “principal” and the person you choose is called an “attorney-in-fact.” The attorney-in-fact must do what you say in your declaration unless a court orders differently or an emergency threatens your life or health.

Your mental health treatment declaration expires in three years. If you are competent, you may cancel your declaration in writing at an earlier time. If you are in mental health treatment, the declaration may last longer than three years and you may not cancel it. Two witnesses must sign the declaration. Your doctor may not be a witness.

### **Do-Not-Resuscitate Order**

You may also ask your doctor about a **do-not-resuscitate order** (DNR order). A DNR order means that cardiopulmonary resuscitation (CPR) will not be started if your heart stops. You and your doctor may decide together that your doctor should write a DNR order into your medical chart. If you have an accident, such as choking on food, the DNR order still allows health care workers to give you the Heimlich maneuver or take other appropriate action.

### **What happens if you don't have an advance directive?**

A health care surrogate may be chosen for you if you cannot make health care decisions and do not have an advance directive. This health care surrogate will be one of the following persons (in order of priority): guardian of the person, spouse, any adult child(ren), either parent, any adult brother or sister, any adult grandchild(ren), a close friend, or guardian of the estate.

The surrogate can make all health care decisions for you, with four exceptions. First, a health care surrogate cannot tell your doctor to withdraw or withhold life-sustaining treatment unless you have a “qualifying condition,” which is a terminal condition, permanent, unconsciousness, or an incurable or irreversible condition. Two doctors must certify that you cannot make decisions and have a qualifying condition in order to withdraw or withhold life-sustaining treatment.

A health care surrogate cannot make decisions concerning mental health treatment, including treatment by electroconvulsive therapy (ECT), psychotropic medication, or admission to a mental health facility. A health care surrogate can petition a court to allow these mental health services.

### **Final Notes**

You should talk to your family, your physician or any agent or attorney-in-fact that you appoint about your decision to make an advance directive. If they know what health care you want, they will find it easier to follow your wishes. If you change your mind and cancel your advance directive, tell your family, your doctor, or any agent or attorney-in-fact you appoint.

No facility, doctor, or insurer can make you execute an advance directive. It is entirely your decision. If a facility, doctor, or insurer objects to following your advance directive, they must tell you and offer you assistance in finding alternative care.

# QUESTIONS AND ANSWERS ON ILLINOIS LIVING WILLS AND POWERS OF ATTORNEY FOR HEALTH CARE

Illinois law gives you the right to accept or reject medical treatment. You also have the right to give directions, in advance, about the kind of health care you want if the time comes when you cannot make your own decisions.

You can control your future health care by signing a form naming a trusted relative or friend to communicate for you and by signing a document that tells the kind of life-sustaining treatment you want. These documents, called advance directives, are written statements you make in advance about your future medical treatment decisions.

## HEALTH CARE POWER OF ATTORNEY

### **What is a health care power of attorney?**

A health care power of attorney is a document you sign that names another person, called your “agent,” to make health care decisions for you if you are unable to do so.

### **Who may create a health care power of attorney?**

Any competent person at least 18 years old may create and sign a health care power of attorney. You do not need a lawyer to complete the document.

### **Who can act as an agent?**

Any person who is at least 18 years old and is able to understand and decide about health care matters can be an agent. However, no physician, nurse, or other health care provider who is giving you treatment may act as your health care agent. Most people choose a trusted relative or friend.

### **What happens if the person I appoint dies or is not able to serve as my agent?**

You may name successor agents to step in and make decisions if your first choice is not able to act. However, you may not have more than one person serving as your agent.

### **What happens if I name my spouse as my agent and we are later divorced?**

Your ex-spouse will no longer have authority to act under the health care power of attorney. Even so, you should attempt to destroy all copies of the power, because doctors or hospitals may rely on it if they do not know of the divorce.

### **Will my agent be held liable for my health care costs?**

No, your agent will not be held personally responsible for the cost of health care services and treatment that he or she arranges.

### **How do I create a health care power of attorney?**

The surest way is to complete and sign the Illinois Statutory Short Form Power of Attorney for Health Care. One witness must also sign the form.

### **What powers do I give to my agent by completing this form?**

After the power of attorney for health care goes into effect, your agent may make any health care decision that you could make if you were able to do so. However, you can limit your agent's powers or give your agent special instructions by clearly stating them in your power of attorney.

### **How do I tell my agent what life-sustaining treatment I want?**

Talk personally with your agent and make sure he or she clearly understands your wishes about life-sustaining treatment. Section two of the Statutory Short Form Power of Attorney for Health Care is about life-sustaining treatment. You may:

1. Leave this section completely blank, giving your agent the broadest power to decide about life-sustaining treatment *OR*
2. Write in your own instructions to your agent *OR*
3. Choose one of the three optional statements that are included in the section.

## **LIVING WILLS**

### **What is a living will?**

A living will (also called a "declaration") is a document you sign that states that you do not want your physician to use death-delaying procedures if you develop a terminal condition.

### **Who may create a living will?**

Any competent person at least 18 years old.

### **How do I create a living will?**

The surest way is to fill out and sign the Living Will Declaration contained in the Illinois Living Will Act. It must be signed by you, or another person at your direction, in the presence of two witnesses.

### **Who can witness the signing of my living will?**

Anyone at least 18 years old who is not entitled to inherit from your estate or financially responsible for your medical care.

### **When does a living will take effect?**

When a physician certifies that you have a terminal condition.

### **What is a “terminal condition”?**

A condition that cannot be cured or reversed, with death imminent, and with the use of death-delaying procedures merely prolonging the dying process.

### **What is a “death-delaying procedure”?**

Death-delaying procedures serve only to postpone the moment of death. They may include assisted ventilation, artificial kidney treatments, medication, blood transfusions, and tube feeding.

### **If I have a living will, can I still receive pain medication?**

Yes, your physician can provide you with pain medication or other care to make you comfortable.

### **What happens if I have a living will and a terminal illness and I am pregnant?**

A living will does not take effect so long as the attending physician believes the fetus could develop to the point of live birth if death-delaying procedures are used for the mother.

## **QUESTIONS ABOUT HEALTH CARE POWERS OF ATTORNEY AND LIVING WILLS**

### **How is a health care power of attorney different from a living will?**

A living will takes effect only if you have a terminal illness and cannot speak for yourself. Also, it addresses only decisions concerning life-sustaining treatment. A health care power of attorney is broader and more flexible and, in that way, is preferable to a living will. Under a health care power of attorney, your agent can make health care decisions for you in any situation when you are unable to do so.

### **Should I have both a health care power of attorney and a living will?**

Your living will does not take effect so long as your agent under a health care power of attorney is available and willing to make life-sustaining treatment decisions. If you do not wish to be kept alive by life-sustaining treatment, you should consider signing both documents because:

The living will reinforces the intent of the power of attorney for health care.

Your agent under the health care power of attorney may die or be unable or unwilling to act when it comes time to make health care decisions.

### **Will hospitals and physicians honor my living will and health care power of attorney?**

Providers must comply with health care decisions of a health care agent or the directions stated in a living will unless they are morally opposed to them. If the provider is unwilling to comply, the provider must inform your agent who is then responsible for arranging your transfer to another provider.

### **For how long are my living will and power of attorney for health care effective?**

They remain valid until you revoke them. However, you should sign a new form every two to three years, since health care providers are more likely to honor a recently signed document.

## **What should I do with my signed health care power of attorney and living will?**

Copies should be given to the persons you have named as the agent and successor agents under the health care power of attorney. Give copies to your physician, family, and friends and discuss your wishes with them as well. Inform your agent where the original documents are kept.

## **In case of an emergency, how will a hospital know that I have a living will or who my health care agent is?**

A hospital can locate your agent or living will if you complete the Health Care Agent/Living Will Wallet Identification Card on the last page of this pamphlet and carry it with you in your wallet or purse.

## **Can I revoke or change my health care power of attorney or my living will?**

They can be revoked at any time, regardless of your physical or mental condition, by doing one of the following:

- Tear up or otherwise destroy the document; *OR*
- Revoke the document in writing, sign and date it, or direct someone else to do it for you; *OR*
- Express (orally or otherwise) in the presence of a witness at least 18 years old, your intent to revoke the document. Have the witness sign and date a statement confirming that such an expression of intent was made.
- To change your health care power of attorney, write in the changes, and sign and date the document. To change your living will, revoke the current form, and sign a new one. Also, a court may revoke or change your documents if it believes clarification is needed or your agent is not acting in your best interests.

## **Should I have my living will and health care power of attorney notarized?**

It is recommended that you have your documents notarized, since some states other than Illinois require notarization.

## **Where can I get the living will and health care power of attorney forms?**

Copies of these forms are:

1. Contained in this booklet. Additional copies are available from Memorial Hospital or:
2. Available by calling or writing your attorney, local hospital, or one of the following:  
The Illinois Department On Aging,  
421 East Capitol Avenue, Springfield, IL 62701 (1-800-252-8966)  
The Illinois Attorney General,  
500 South Second Street, Springfield, IL 62706 (1-800-252-2518)

# MENTAL HEALTH TREATMENT PREFERENCE DECLARATION

## **What is a mental health treatment preference declaration?**

It is a document you sign to state your wishes to receive psychotropic drugs, electroconvulsive treatment, or be admitted to a mental health facility for up to 17 days, if you are unable to make your own decisions. You may either write your wishes or choose someone to make your mental health treatment decisions for you.

## **How does a mental health treatment preference declaration differ from other advance directives?**

If you have a mental health treatment declaration and you need mental health treatment, you may not revoke the declaration. The Power of Attorney for Health Care and Living Will may be revoked at any time regardless of your mental condition.

## **How do I create a mental health treatment preference declaration?**

Complete and sign the Declaration For Mental Health Treatment contained in the “Mental Health Treatment Preference Declaration Act.”

# HEALTH CARE SURROGATES

## **What if I do not have a living will or power of attorney for health care?**

Under the Health Care Surrogate Act, an individual, called a “surrogate,” may make medical treatment decisions for you if you do not have a power of attorney for health care or a living will and are unable to make your own health care decisions.

## **What decisions can a surrogate make?**

A surrogate can make decisions about your routine medical treatment, and, if two physicians say you have a terminal illness, permanent unconsciousness, or an irreversible condition that causes severe pain or imposes an inhumane burden on you, about life-sustaining treatment. A surrogate may not make decisions concerning electroconvulsive therapy, or psychotropic drugs, or admission to a mental health facility.

## **Who may act as a surrogate?**

Your physician will identify one person as your surrogate, in the following order of priority:

1. Court-appointed guardian (most persons will not have a guardian)
2. Your spouse
3. Any of your adult children
4. Either of your parents
5. Any of your adult brothers or sisters
6. Any of your adult grandchildren
7. One of your close friends
8. Guardian of your estate

## **With a health care surrogate, why should I create a health care power of attorney?**

A health care power of attorney allows you to name your agent and give him or her instructions now, while you are still able to communicate. A surrogate may not know your wishes.

# ILLINOIS LIVING WILL DECLARATION

*This* declaration is made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

**I**, \_\_\_\_\_, 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.

**Specific Instructions:** \_\_\_\_\_

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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* \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

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 related to the declarant by blood, marriage or adoption;

At the date of this instrument, I am not related to the declarant by blood, marriage or adoption; 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 the declarant or other instrument taking effect at the declarant's death, or directly financially responsible for the declarant's medical care.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_

\_\_\_\_\_

# 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 THE 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 IN 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 (SEE APPENDIX C). 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 and year)

I, \_\_\_\_\_  
(insert name and address of principal)

hereby appoint: \_\_\_\_\_  
(insert 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 AGENTS' 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 life-sustaining 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, electro-convulsive 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):

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.

Initialed \_\_\_\_\_

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.

Initialed \_\_\_\_\_

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.

Initialed \_\_\_\_\_

(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 APPENDIX C). 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. o 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)

Initialed \_\_\_\_\_

4. o This power of attorney shall terminate on \_\_\_\_\_

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

Initialed \_\_\_\_\_

(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:

a. \_\_\_\_\_  
(insert name, address, and telephone number of successor agent)

b. \_\_\_\_\_  
(insert name, address, and telephone number of successor agent)

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or 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, 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 \_\_\_\_\_

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)

# APPENDIX C

The powers you give your agent, your right to revoke those powers and the penalties for violating the law are more fully explained herein.

## **4-5: Limitations on Health Care Agencies**

Neither the attending doctor nor any other health care provider may act as agent under a health care agency; however, a person who is not administering health care to the patient may act as health care agent for the patient even though the person is a doctor or otherwise licensed, certified, authorized, or permitted by law to administer health care in the ordinary course of business or the practice of a profession.

## **4-6: Revocation and Amendment of Health Care Agencies**

- (a) Every health care agency may be revoked by the principal at any time, without regard to the principal's mental or physical condition, by any of the following methods:
  - 1. By being obliterated, burnt, torn or otherwise destroyed or defaced in a manner indicating intention to revoke;
  - 2. By a written revocation of the agency signed and dated by the principal or person acting at the direction of the principal; or
  - 3. By an oral or any other expression of the intent to revoke the agency in the presence of a witness 18 years of age or older who signs and dates a writing confirming that such expression of intent was made.
- (b) Every health care agency may be amended at any time by a written amendment signed and dated by the principal or person acting at the

direction of the principal.

- (c) Any person, other than the agent, to whom a revocation or amendment is communicated or delivered shall make all reasonable efforts to inform the agent of that fact as promptly as possible.

## **4-9: Penalties**

All persons shall be subject to the following sanctions in relation to health care agencies, in addition to all other sanctions applicable under any other law or rule of professional conduct:

- (a) Any person shall be civilly liable who, without the principal's consent, willfully conceals, cancels or alters a health care agency or any amendment or revocation of the agency or who falsifies or forges a health care agency amendment or revocation.
- (b) A person who falsifies or forges a health care agency or willfully conceals or withholds personal knowledge of an amendment or revocation of a health care agency with the intent to cause a withholding or withdrawal of life-sustaining or death-delaying procedures contrary to the intent of the principal and thereby, be cause of such act, directly causes life-sustaining or death-delaying procedures to be withheld or withdrawn and death to the patient to be hastened shall be subject to prosecution for involuntary manslaughter.
- (c) Any person who requires or prevents execution of a health care agency as a condition of insuring or providing any type of health care services to the patient shall be civilly liable and guilty of a Class A misdemeanor.

#### **4-10(b) Statutory Short Form Power of Attorney for Health Care**

The statutory short form power of attorney for health care (the “statutory health care power”) authorizes the agent to make any and all health care decisions on behalf of the principal which the principal could make if present and under no disability, subject to any limitations on the granted powers that appear on the face of the form, to be exercised in such manner as the agent deems consistent with the intent and desires of the principal. The agent will be under no duty to exercise granted powers or to assume control of or responsibility for the principal’s health care; but when granted powers are exercised, the agent will be required to use due care to act for the benefit of the principal in accordance with the terms of the statutory health care power and will be liable for negligent exercise. The agent may act in person or through others reasonable employed by the agent for that purpose but may not delegate authority to make health care decisions. The agent may sign and deliver all instruments, negotiate and enter into all agreements and do all other acts reasonably necessary to implement the exercise of the powers granted to the agent. Without limiting the generality of the foregoing, the statutory health care power shall include the following powers, subject to any limitations appearing on the face of the form:

- (1) The agent is authorized to give consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment or procedures relating to the physical or mental health of the principal, including any medication program, surgical procedures, life-sustaining treatment or provisions of food and fluids for the principal.
- (2) The agent is authorized to admit the principal to or discharge the principal from any and all types of hospitals, institutions, homes, residential or nursing facilities, treatment centers and other health care institutions providing personal care or treatment for any type of physical or mental condition. The agent shall have the

same right to visit the principal in the hospital or other institution as is granted to a spouse or adult child of the principal, any rule of the institution to the contrary notwithstanding.

- (3) The agent is authorized to contract for any and all types of health care services and facilities in the name of and on behalf of the principal and to bind the principal to pay for all such services and facilities, and to have and exercise those powers over the principal’s property as are authorized under the statutory property power, to the extent the agent deems necessary to pay health care costs; and the agent shall not be personally liable for any services or care contracted for on behalf of the principal.
- (4) At the principal’s expense and subject to reasonable rules of the health care provider to prevent disruption of the principals’ health care, the agent shall have the same right the principal has to examine and copy and consent to disclosure of all the principal’s medical records that the agent deems relevant to the exercise of the agent’s powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any doctor, psychiatrist, psychologist, therapist, hospital, nursing home, or other health care provider.
- (5) The agent is authorized to direct that an autopsy be made pursuant to Section 2 of “An Act in relation to autopsy of dead bodies”, approved August 13, 1965, including all amendments; to make a disposition of any part or all of the principal’s body pursuant to the Uniform Anatomical Gift Act, as now or hereafter amended; and to direct the disposition of the principal’s remains.

WALLET  
CARDS  
FOR  
ILLINOIS  
ADVANCE  
DIRECTIVES

Cut out and complete the cards at the right. Put one card in the wallet or purse you carry most often, along with your driver's license or health insurance card. You can keep the second card on your refrigerator, in your motor vehicle glove compartment, a spare wallet or purse, or other easy-to-find place.



MEMORIAL  
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*Dedication. Compassion. Innovation.*

**HEALTH CARE AGENT / LIVING WILL  
WALLET IDENTIFICATION CARD**

My Name Is: \_\_\_\_\_

I have signed a Power of Attorney for Health Care authorizing my named agent to make my health care decisions for me if I am unable to do so.

My Health Care Agent Is: \_\_\_\_\_

His/Her Phone Numbers Are:  
(H) \_\_\_\_\_ (W) \_\_\_\_\_

My Successor Health Care Agent Is:  
\_\_\_\_\_

His/Her Phone Numbers Are:  
(H) \_\_\_\_\_ (W) \_\_\_\_\_

I have signed a Living Will. If I am suffering from a terminal condition, a copy may be obtained from:

Name: \_\_\_\_\_

His/Her Phone Numbers Are:  
(H) \_\_\_\_\_ (W) \_\_\_\_\_

**HEALTH CARE AGENT / LIVING WILL  
WALLET IDENTIFICATION CARD**

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(H) \_\_\_\_\_ (W) \_\_\_\_\_

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\_\_\_\_\_

His/Her Phone Numbers Are:  
(H) \_\_\_\_\_ (W) \_\_\_\_\_

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(H) \_\_\_\_\_ (W) \_\_\_\_\_