



POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, _____, being of sound mind, do hereby designate:

_____, to serve as my Attorney-in-Fact, for the purpose of making medical treatment decisions for me (including the withholding or the withdrawal of life-sustaining procedures, nutrition, hydration) should I be diagnosed and certified as having a terminal and irreversible condition and be comatose, incompetent, or otherwise mentally or physically unable to make such decisions for myself.

Dated: _____ (Declarant's signature)

Address: _____

City/state: _____

Parish: _____

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

Dated: _____ (Witness)

Dated: _____ (Witness)