A CATHOLIC HEALTH CARE DIRECTIVE[1]

Attached is my Medical Durable Power of Attorney for Health Care Decisions. As a Catholic, I believe that God created me for eternal life in union with Him. I understand that my life is a precious gift from God and this truth should inform all decisions with regards to my health care. I have a duty to preserve my life and use it for God's glory. Suicide, euthanasia, and acts that intentionally and directly would cause my death by deed or omission, are never morally acceptable. However, I also know that death, being conquered by Christ, need not be resisted by any and every means and that I may refuse any medical treatment that is excessively burdensome or would only prolong my imminent death. Those caring for me should avoid doing anything that is contrary to the moral teaching of the Catholic Church.

- Medical treatments may be foregone or withdrawn if they do not offer a reasonable hope of benefit to me or are excessively burdensome.

- There should be a presumption in favor of providing me with nutrition and hydration, including medically assisted nutrition and hydration, unless they are of no benefit to me.

- In accord with the teachings of my Church, I have no moral objection to the use of medication or procedures necessary for my comfort even if they may indirectly and unintentionally shorten my life.

- If my death is imminent, I direct that there be foregone or withdrawn treatment that will only maintain a precarious and burdensome prolongation of my life, unless those responsible for my care judge at that time that there are special and significant reasons why I should continue to receive such treatment.

- If I fall terminally ill, I ask that I be told of this so that I might prepare myself for death, and I ask that efforts be made that I be attended by a Catholic priest and receive the Sacraments of Reconciliation, Anointing, and Eucharist as viaticum.

ANY OTHER DESIRES, PROVISIONS, OR LIMITATIONS CONCERNING LIFE-PROLONGING CARE, TREATMENT, SERVICES OR PROCEDURES HAVE BEEN INCLUDED IN MY MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

PLEASE CONTACT AN ATTORNEY IF YOU HAVE LEGAL QUESTIONS REGARDING ADVANCE CARE PLANNING

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[1] A resource taken from the *North Dakota Catholic Conference*: http://ndcatholic.org/CHD/

MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

1. I, ________________________________, Declarant, hereby appoint:
(Print or Type Your Name)

____
Name of Agent

____
Agent's Home Telephone Number

____
Agent's Work Telephone Number

____
Agent's Home Address

as my agent to make health care decisions for me if and when I am unable to make my own health care decisions. This gives my agent the power to consent, to refuse or stop any health care, treatment, service or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information and sign forms necessary to carry out those decisions.

If the person named as my agent is not available or is unable to act as my agent, then I appoint the following person(s) to serve in the order listed below:

2. ________________________________
Agent Name

____
Home Telephone # *Work Telephone #*

3. ________________________________
Agent Name

____
Home Telephone # *Work Telephone #*

By this document I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity.

My agent shall make health care decisions as I may direct below or as I make known to him or her in some other way (see *My Beliefs*). If I have not expressed a choice about the health care in question, my agent shall base his/her decision on what he/she believes to be in my best interest.

(A) Statement of desires concerning life-prolonging care, treatment, services and procedures (*use extra sheet, if needed*):

____
____
____
____
____

(B) Special provisions and limitations (*use extra sheet, if needed*):

____
____
____
____
____

Making an Anatomical Gift (OPTIONAL)
So long as it is consistent with Catholic moral teaching, I would like to be an organ donor at the time of my death. I wish to donate the following (initial one statement):
[ ] Any needed organs and tissue.

[ ] Only the following organs and tissue:

BY SIGNING HERE, I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCMENT.

____

SIGNATURE OF PERSON CREATING MEDICAL DURABLE POWER OF ATTORNEY (DECLARANT) DATE

(OPTIONAL BUT RECOMMENDED)
*Colorado law does not require this instrument to be witnessed; however, it is recommended to obtain the signature of two witnesses or a notary. This is not required by Colorado law but **may** make this document more acceptable in other states.*

WITNESS:
Signature:___________________________
Home Address:________________________
____
Date:________________________________

WITNESS:
Signature:___________________________
Home Address:________________________
____
Date:________________________________