

NAME OF DECLARANT _____ DOB _____

ADDRESS _____ PHONE# _____

1. Appointment of Agent and Alternates

I, the Declarant, hereby appoint:

Name of Agent- Relationship _____

Agent's Best Contact Telephone Number _____

Agent's Home Address _____

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, refuse, or stop any healthcare, treatment, service or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

Name of Alternate Agent #1- Relationship _____

Agent's Best Contact Telephone Number _____

Agent's Home Address _____

Name of Alternate Agent #2- Relationship _____

Agent's Best Contact Telephone Number _____

Agent's Home Address _____

2. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines to be in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

Optional: State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

My signature below indicates that I understand the purpose and effect of this document. I do hereby revoke and cancel any and all prior Medical Powers of Attorney that I may have previously done and executed:

Signature of Declarant _____ Date _____

3. Signature of Witnesses and Notary (Optional)

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We are at least eighteen (18) years old.

Signature of Witness _____

Printed Name _____

Address _____

Signature of Witness _____

Printed Name _____

Address _____

Notary (Optional)

State of _____

County of _____

SUBSCRIBED and sworn to before me by _____

_____, the Declarant, as

the voluntary act and deed of the Declarant this _____ day

of _____, 20 _____

Notary Public _____

My commission expires: _____