

**Acceptance of Patient Advocate**

*The Patient Advocate and any successor Patient Advocate must sign this Acceptance before he/she may act as Patient Advocate.*

I agree to be the Patient Advocate for \_\_\_\_\_ (called "Patient" in the rest of this document). I accept the Patient's designation of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the Patient as indicated in the Designation of Patient Advocate, in other written instructions of the Patient and as we have discussed verbally.

I also understand and agree that:

- a. This designation shall not become effective unless the Patient is unable to participate in medical treatment decisions.
- b. A Patient Advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the Patient, if the Patient were able to participate in the decision, could not have exercised on his or her own behalf.
- c. This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a Patient who is pregnant that would result in the pregnant Patient's death.
- d. A Patient Advocate may make a decision to withhold or withdraw treatment which would allow a Patient to die only if the patient has expressed in a clear and convincing manner that the Patient Advocate is authorized to make such a decision and that the Patient acknowledges that such a decision could or would allow the Patient's death.
- e. A Patient Advocate shall not receive compensation for the performance of his or her authority, rights and responsibilities, but a Patient Advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights and responsibilities.
- f. A Patient Advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the Patient and shall act consistent with the Patient's best interests. The known desires of the Patient expressed or evidenced while the Patient is able to participate in medical treatment decisions are presumed to be in the Patient's best interests.

**These restrictions are required by the Patient Advocate Act of 1990, P.A. No. 312 (MCLA 700.496)**

- g. A Patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
- h. A Patient Advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.
- i. A Patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 or the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Laws.

If I am unavailable to act after reasonable effort to contact me, I delegate my authority to the persons the Patient has designated as Successor Patient Advocate in the order designated. The Successor Patient Advocate is authorized to act until I become available to act.

**PATIENT ADVOCATE**

Sign Name \_\_\_\_\_

Name \_\_\_\_\_  
type or print

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Successor PATIENT ADVOCATE**

Sign Name \_\_\_\_\_

Name \_\_\_\_\_  
type or print

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Successor PATIENT ADVOCATE**

Sign Name \_\_\_\_\_

Name \_\_\_\_\_  
type or print

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**DESIGNATION OF PATIENT ADVOCATE FORM and DIRECTIONS for HEALTH CARE Durable Power of Attorney for Health Care**



This is an important legal document. You should discuss it with your doctor and attorney if you have questions.

**Appointment of Patient Advocate**

**Here you name someone to act for you regarding your care, custody and treatment. This person is called a "Patient Advocate." You may name anyone who is at least eighteen years old and of sound mind. You may also name one or more persons to act if your first choice cannot.**

**If you change your mind, you may revoke your appointment of a Patient Advocate at any time.**

**To my Family, Doctors and All Concerned with my care:**

These instructions express my wishes about my health care. I want my family, doctors and everyone else concerned with my care to act in accord with them.

I appoint the following person my Patient Advocate:

Patient Advocate's Name \_\_\_\_\_  
type or print

Address \_\_\_\_\_

Telephone \_\_\_\_\_

**Appointment of Successor Patient Advocate(s)**

I appoint the following person(s), in the order listed, my Successor Patient Advocate if my Patient Advocate does not accept my appointment, is incapacitated, resigns or is removed. My Successor Patient Advocate is to have the same powers and rights as my Patient Advocate.

Name \_\_\_\_\_  
type or print

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Name \_\_\_\_\_  
type or print

Address \_\_\_\_\_

Telephone \_\_\_\_\_

My Patient Advocate or Successor Patient Advocate may delegate his/her powers to the next Successor Patient Advocate if he or she is unable to act.

My Patient Advocate or Successor Patient Advocate may only act if I am unable to participate in making decisions regarding my medical treatment.

**Instructions for Care**

**This section gives instructions for your care. Cross out and initial any instructions you do not want.**

**Under instruction I.b., your Patient Advocate has the right to make arrangements for your care but is not required personally to pay the cost of your care.**

**Note: Current law does not permit your Patient Advocate to make decisions to withhold or withdraw treatment if you are pregnant if that decision would result in your death, to engage in homicide or euthanasia, or to force medical treatment you do not want because of your religious beliefs.**

**You may list specific care and treatment you do or do not want. Otherwise, your general instructions will stand for your wishes.**

**1. General Instructions**

My Patient Advocate shall have the authority to make all decisions and to take all actions regarding my care, custody and medical treatment including, but not limited, to the following:

- a. Have access to, obtain copies of and authorize release of my medical and other personal information.
- b. Employ and discharge physicians, nurses, therapists and any other health care providers and arrange to pay them reasonable compensation.
- c. Consent to, refuse or withdraw for me any medical care; diagnostic, surgical or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatments. I understand that life-sustaining treatment includes, but is not limited to, breathing with the use of a machine and receiving food, water and other liquids through tubes. I also understand that these decisions could or would allow me to die. I have listed below any specific instructions I have related to life-sustaining treatments.

**2. Specific Instructions**

My Patient Advocate is to be guided in making medical decisions for me by what I have told him/her about my personal preferences regarding my care. Some of my preferences are recorded below and on the following page.

**a. Specific Instructions Regarding Care I Do Want.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**b. Specific Instructions Regarding Care I Do Not Want.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**You do not have to choose one of the specific instructions about life-sustaining treatment in this section. But if you do, sign only one instruction.**

**You should discuss these choices with your doctor.**

**c. Specific Instructions Regarding Life-Sustaining Treatment.**

I understand that I do not have to choose one of the instructions regarding life-sustaining treatment listed below. If I choose one, I will sign below my choice.

**Choice 1:** I do not want my life to be prolonged by providing or continuing life-sustaining treatment if any of the following medical conditions exist.

I am in an irreversible coma or persistent vegetative state.

I am terminally ill and life-sustaining procedures would serve only to artificially delay my death.

Under any circumstances where my medical condition is such that the burdens of the treatment outweigh the expected benefits. In weighing the burdens and benefits of treatment, I want my Patient Advocate to consider the relief of suffering and the quality of my life as well as the extent of possibly prolonging my life.

I understand that this decision could or would allow me to die.

*If this statement reflects your desires, sign here:* \_\_\_\_\_

**Choice 2:** I want my life to be prolonged by life-sustaining treatment unless I am in a coma or vegetative state which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued. I understand that this decision could or would allow me to die.

*If this statement reflects your desires, sign here:* \_\_\_\_\_

**Choice 3:** I want my life to be prolonged to the greatest extent possible consistent with sound medical practice without regard to my condition, the chances I have for recovery or the cost of my care and I direct life-sustaining treatment be provided in order to prolong my life.

*If this statement reflects your desires, sign here:* \_\_\_\_\_

**d. Specific Instructions Regarding Medical Examinations**

My religious beliefs prohibit a medical examination to determine whether I am unable to participate in making medical treatment decisions. I desire this determination to be made in the following manner:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This document is to be treated as a Durable Power of Attorney for Health Care and shall survive my disability or incapacity.

If I am unable to participate in making decisions for my care and there is no Patient Advocate or Successor Patient Advocate able to act for me, I request that the instructions I have given in this document be followed and that this document be treated as conclusive evidence of my wishes.

It is also my intent that anyone participating in my medical treatment shall not be liable for following the directions of my Patient Advocate that are consistent with my instructions.

This document is signed in the State of Michigan. It is my intent that the laws of the State of Michigan govern all questions concerning its validity, the interpretation of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

Photocopies of this document can be relied upon as though they were originals.

I am providing these instructions of my free will. I have not been required to give them in order to receive or have care withheld or withdrawn. I am at least eighteen years old and of sound mind.

**Signature**

Sign Name \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_  
type or print

Address \_\_\_\_\_

**Sign and date here in the presence of at least two witnesses who meet the requirements listed in the witness statement below.**

**If the witness does not personally know the person who is signing this Designation, the witness should ask for identification, such as a driver's license.**

**Only two witnesses are required. Using three will protect the validity of the Designation if one witness is later found ineligible to be a witness.**

**Keep the signed original with your personal papers at home. Give signed copies to your doctor, family, the medical facility where you are being treated and to Patient Advocates. You should review this document from time to time and when there is a change in your health or family status. When you review it, if it still expresses your intent, date and sign under the Reaffirmed section below to show you still agree with its contents. If your wishes change, destroy this document, make a new one and give a copy to everyone who has a copy of the old version.**

**You should discuss this document with the person you want to have as your Patient Advocate and have him/her sign the Acceptance of Patient Advocate on the next page.**

**Witness Statement and Signature**

I declare that the person who signed this Designation of Patient Advocate signed it in my presence and is known to me. I also declare that the person who signed appears to be of sound mind and under no duress, fraud or undue influence and is not my husband or wife, parent, child, grandchild, brother or sister. I declare that I am not the presumptive heir of the person who signed above on this page, the known beneficiary of his/her will at the time of witnessing, his/her physician or a person named as the Patient Advocate. I also declare that I am not an employee of a life or health insurance provider for the person who signed, an employee of a health facility that is treating him/her, or an employee of a home for the aged where he/she resides and that I am at least eighteen years old.

**Witnesses**

Sign Name \_\_\_\_\_ Sign Name \_\_\_\_\_ Sign Name \_\_\_\_\_

Name \_\_\_\_\_ Nam \_\_\_\_\_ Name \_\_\_\_\_  
type or print type or print type or print

Address \_\_\_\_\_ Address \_\_\_\_\_ Address \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

**REAFFIRMED**

Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_