DURABLE POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF HEALTH CARE ATTORNEY IN FACT

I, _____ appoint:

Name: _____

Address: _____

_____

Phone: _____

as my attorney in fact to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY ATTORNEY IN FACT ARE AS FOLLOWS:

_____

_____

_____

_____

_____

_____

DESIGNATION OF ALTERNATE HEALTH CARE ATTORNEY IN FACT

(*You are not required to designate an alternate attorney in fact but you may do so. An alternate attorney in fact may make the same health care decisions as the designated attorney in fact if the designated attorney in fact is unable or unwilling to act as your attorney in fact. If the attorney in fact designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved or annulled*.)

If the person designated as my attorney in fact is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my attorney in fact to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Attorney in Fact

Name: _____

Address: _____

_____

Phone: _____

B. Second Alternate Attorney in Fact

Name: _____

Address: _____

_____

Phone: _____

The original of this document is kept at _____

_____.

The following individuals or institutions have signed copies:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

DURATION

I understand that this durable power of attorney for health care exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this durable power of attorney expires, the authority I have granted my attorney in fact continues to exist until the time I become able to make health care decisions for myself.

(*IF APPLICABLE*) This durable power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED

I revoke any prior durable powers of attorney for health care.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

I sign my name to this durable power of attorney for health care on _____ day of

_____, 20_____, at _____.

_____ Signature

_____ Print Name

FIRST WITNESS:

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a treating health care provider, an employee of a treating health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility, nor an employee of an operator of a residential care facility.

I sign my name to this durable power of attorney for health care on _____ day of

_____, 20_____, at _____.

_____ Signature

_____ Print Name

SECOND WITNESS:

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a treating health care provider, an employee of a treating health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility, nor an employee of an operator of a residential care facility.

I further declare under penalty of perjury under the laws of Wyoming that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

I sign my name to this durable power of attorney for health care on _____ day of

_____, 20_____, at _____.

_____ Signature

_____ Print Name