

POWER OF ATTORNEY  
ILLINOIS STATUTORY  
POWER OF ATTORNEY FOR HEALTH CARE

(NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR "AGENT") BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME OR OTHER INSTITUTION. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT WHEN POWERS ARE EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM AND KEEP A RECORD OF RECEIPTS, DISBURSEMENTS AND SIGNIFICANT ACTIONS TAKEN AS AGENT. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME SUCCESSOR AGENTS UNDER THIS FORM BUT NOT CO-AGENTS, AND NO HEALTH CARE PROVIDER MAY BE NAMED. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW, UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN HERE THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN SECTIONS 4-5, 4-6, 4-9 AND 4-10(B) OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW" OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS FORM). THAT LAW EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.)

POWER OF ATTORNEY made this \_\_\_\_\_ day of \_\_\_\_\_, 200\_.

(1) I, \_\_\_\_\_ of Arlington Heights, Illinois, hereby appoint: \_\_\_\_\_ of \_\_\_\_\_, Illinois, as my attorney-in-fact (my "agent") to act for and in my name (in any way I could in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy and direct the disposition of my remains.

(2) The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that re inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.):

NO LIMITATIONS.

THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT; BUT DO NOT INITIAL MORE THAN ONE:

\_\_\_\_\_ I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent  
Initialed believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

\_\_\_\_\_ I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a  
Initialed coma which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

\_\_\_\_\_ I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for

Initialed \_\_\_\_\_ recovery or the cost of the procedures.

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU IN THE MANNER PROVIDED IN SECTION 4-6 OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW". ABSENT AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH, AND BEYOND IF ANATOMICAL GIFT, AUTOPSY OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING.

(3) This power of attorney shall become effective upon determination by my attending physician that I am not capable of making any such decisions due to my disability.

(4) This power of attorney shall terminate upon my death.

(5) If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following as successor to such agent:

\_\_\_\_\_

(6) If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

(7) I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

\_\_\_\_\_  
**Name**

I certify that **name** has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

\_\_\_\_\_ residing \_\_\_\_\_ at:

Specimen signature of my agent.

I certify that the signatures of my agent (and successors) are correct.

\_\_\_\_\_  
**Attorney-in-Fact,**

\_\_\_\_\_  
**NAME**

Specimen signature of my successor agent in the event my agent is unable to act.

\_\_\_\_\_  
**Successor Agent,**

**NAME**



STATE OF ILLINOIS    )  
                                  ) SS.  
COUNTY OF COOK    )

The undersigned, a notary public in and for the above county and state, certifies that \_\_\_\_\_, is known to me to be the same person whose name is subscribed as principal to the foregoing durable power of attorney, that she/he appeared before me in person and acknowledged signing and delivering the instrument as the free and voluntary act of the principal, for the uses and purposes therein set forth and certified to the correctness of the signature(s) of the agent(s).

SUBSCRIBED AND SWORN TO BEFORE ME  
THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

THIS DOCUMENT WAS PREPARED BY:

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