Hawaii Durable Power of Attorney for Health Care Decisions
Will to Live Form

DESIGNATION OF AGENT

I, (your name)____

(your address)____

____

(your phone number)____

designate the following individual as my agent to make health-care decisions for me:

(Name of agent)____

(address of agent)____

(phone number(s) of agent)____

OPTIONAL: If I revoke my agent's authority, or if my agent is not willing, able, or reasonably available to make health-care decisions for me, I designate as my first alternate agent:

First Successor Agent

(successor agent's name)____

(successor agent's address)____

____

(successor agent's phone number)____

OPTIONAL: If I revoke the authority of my agent and first alternate agent, or if neither is willing, able, or reasonably available to make health-care decisions for me, I designate as my second alternate agent:

Second Successor Agent

(second successor agent's name)____

(second successor agent's address)____

____

(second successor agent's phone number)_____________________________________

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box, my agent's authority to make health-care decisions for me takes effect immediately.

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☐ My agent's authority to make health-care decisions takes effect immediately

INSTRUCTIONS FOR HEALTH CARE:

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care attorney in fact(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care attorney in fact to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

–all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

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I direct my health care provider(s) and health care attorney in fact to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my attorney in fact, as named below, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn: **(Be as specific as possible; SEE SUGGESTIONS.):**

____
____
____
____
____
____

(Cross off any remaining blank lines.)

WHEN I AM TERMINALLY ILL

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

(Be as specific as possible; SEE SUGGESTIONS.):

____
____
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(Cross off any remaining blank lines.)

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C. OTHER SPECIAL CONDITIONS:
(Be as specific as possible; SEE SUGGESTIONS.):

____
____
____
____
____
____
(Cross off any remaining blank lines.)

IF I AM PREGNANT
D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care attorney in fact(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

____
Signature of Declarant

EFFECT OF COPY
A copy of this form has the same effect as the original.

Signed this ____________________day of ___________________________, 20_______.

(Signature)____

(Print Name)____

WITNESSES

This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.

FIRST ALTERNATIVE
I declare under penalty of false swearing pursuant to §710-102, Hawaii Revised Statutes, that the

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principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. 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.

First Witness Signature:____

Date:_____________________________ Address:________________________

Print Name:________________________ ______________________________

I declare under penalty of false swearing pursuant to §710-102, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

Second Witness Signature:____

Date:_____________________________ Address:________________________

Print Name:________________________ ______________________________

SECOND ALTERNATIVE

NOTARY PUBLIC

State of Hawaii
County of_________________________

On this ________ day of ____________________, 20_____, before me (name of notary public) ____, personally known to be (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal

____
Signature of Notary Public

My commission expires:_______________________

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*clerical changes made 11/05

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