HEALTH CARE POWER OF ATTORNEY

(South Carolina Statutory Form, Code of Laws Section 62-5-504)

INFORMATION ABOUT THIS DOCUMENT

This is an important legal document. Before signing this document, you should know these important facts:

1. This document gives the person you name as your agent the power to make health care decisions for you if you cannot make the decisions for yourself. This power includes the power to make decisions about life-sustaining treatment. Unless you state otherwise, your agent will have the same authority to make decisions about your healthcare, as you would have.

2. This power is subject to any limitations or statements of your desires that you include in this document. You may state in this document any treatment you do not desire or treatment you want to be sure you receive. Your agent will be obligated to follow your instructions when making decisions on your behalf. You may attach additional pages if you need more space to complete the statement.

3. After you have signed this document, you have the right to make health care decision for yourself if you are mentally competent to do so. After you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.

4. You have the right to revoke this document, and terminate your agent's authority, by informing either your agent or your health care provider orally or in writing.

5. If there is anything in this document that you do not understand, you should ask a social worker, lawyer, or other person to explain it to you.

6. This power of attorney will not be valid unless two persons sign as witnesses. Each of these persons must either witness your signing of the power of attorney or witness your acknowledgement that the signature on the power of attorney is yours.

   The following persons may not act as witnesses:

   A. Your spouse; your children, grandchildren, and other linear descendants; your parent, grandparents, and other linear ancestors; your siblings and their linear descendants; or a spouse of any of these persons.
   B. A person who is directly financially responsible for your medical care.
   C. A person who is named in your will, or, if you have no will, who would inherit your property by intestate succession.
   D. A beneficiary of a life insurance policy on your life.

   E. The persons named in the Health Care Power of Attorney as your agent or successor agent.
   F. Your physician or an employee of your physician
   G. Any person who would have a claim against any portion of your estate (persons to whom you owe money).

If you are a patient in a health facility, no more than one witness may be an employee of that facility.

7. Your agent must be a person who is 18 years old or older and of sound mind. It may not be your doctor or any other health care provider that is now providing you with treatment or an employee of your doctor or provider; or a spouse of the doctor, provider, or employee; unless the person is a relative of yours.

8. You should inform the person that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. If you are in a health care facility or a nursing care facility, a copy of this document should be included in your medical record.

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1. DESIGNATION OF HEALTH CARE AGENT

I, _____, (_____/_____/_____)
(*Principal*) (*Social Security Number*)

hereby appoint: _____
(*Agent*)

_____
(*Address*)
_____

Home Telephone: _____ Work Telephone: _____ as my agent to make health care decision for me as authorized in this document.

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence.

3. AGENT'S POWERS

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desire is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, unless specifically limited by Section E. below, my agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service;

D. To take any other action necessary to making, documenting, and assuring implementation of

decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

E. The powers granted above do not include the following powers or are subject to the following rules or limitations: _____
_____
_____
_____

4. ORGAN DONATION (INITIAL ONLY ONE)
My agent may _____; may not _____ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

5. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)
I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situation to which the Declaration does not apply.

6. STATEMENT OF DESIRES AND SPECIAL PROVISIONS
With respect to any Life-Sustaining Treatment. I direct the following: (INITIAL ONLY ONE OF THE FOLLOWING 4 PARAGRAPHS)

(1) _____ GRANT OF DISCRETION TO AGENT, I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(2) _____DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or
b. if I am in a state of permanent unconsciousness.

OR

(3) _____ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my

condition, the chances I have for recovery, or the cost of the procedures.

OR

(4) _____ DIRECTIVE IN MY OWN WORDS: _____

_____

_____

_____

_____

7. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that (INITIAL ONLY ONE)

_____ I do not want to receive these forms of artificial nutrition and hydration, and they may be withheld or withdrawn under the conditions given above.

OR

_____ I do want to receive these forms of artificial nutrition and hydration.

IF YOU DO NOT INITIAL EITHER OF THE ABOVE STATEMENT, YOUR AGENT WILL NOT HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

8. SUCCESSORS

If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named.

A. First Alternate Agent: _____

Address: _____

_____ Telephone: _____

B. Second Alternate Agent: _____

Address: _____

_____ Telephone: _____

9. ADMINISTRATIVE PROVISIONS

A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

10. UNAVAILABILITY OF AGENT

If at any relevant time the Agent or Successor Agents named herein are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian. Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I sign my name to this Health Care Power of Attorney on this _____ day of _____, 20 ___. My current home address is: _____

_____

Signature: _____

Print Name: _____

WITNESS STATEMENT

I declare, on the basis of information and belief, that person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his/her decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principals estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care agent or Successor Health Care Agent by this document.

Witness No. 1:

Signature: _____ Date: _____

Print Name: _____Telephone: _____

Residence Address: _____

_____

Witness No. 2:

Signature: _____ Date: _____

Print Name: _____Telephone: _____

Residence Address: _____

_____