**DECLARATION AS TO MEDICAL OR SURGICAL TREATMENT**

I, _____, being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

1. If at any time any attending physician and one other physician certify in writing that:
   a. I have an injury, disease or illness which is not curable or reversible and which, in their judgment, is a terminal condition; and
   b. For a period of seven consecutive days or more, I have been unconscious, comatose or otherwise incompetent so as to be unable to make or communicate responsible decisions concerning my person; then I direct that, in accordance with Colorado law, life-sustaining procedures shall be withdrawn and withheld pursuant to the terms of this declaration; it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain. However, I may specifically direct, in accordance with Colorado law, that artificial nourishment be withdrawn or withheld pursuant to the terms of this declaration.
2. In the event that the only procedure I am being provided is artificial nourishment, I direct that one of the following actions be taken:
   ___(initials of declarant) **a**. Artificial nourishment shall not be continued when it is the only procedure being provided; or
   ___(initials of declarant) **b**. Artificial nourishment shall be continued for ___ days when it is the only procedure being provided; or
   ___(initials of declarant) **c**. Artificial nourishment shall be continued when it is the only procedure being provided.
3. I execute this declaration as my free and voluntary act this ___ day of this month, _____, in this year of _____.

By_____
Declarant

The foregoing instrument was signed and declared by _____ to be his/her declaration, in the presence of us, who, in his/her presence, in the presence of each other, and at his/her request, have signed our names below as witnesses, and we declare that, at the time of the execution of this instrument, the declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that neither of us is: 1) a physician; 2) the declarant's physician or an employee of his/her physician; 3) an employee or a patient of the health care facility in which the declarant is a patient; or 4) a beneficiary or creditor of the estate of the declarant.

Dated at _____, Colorado, this _____ day of _____, in the year _____.

| | |
|---|---|
| _____ | _____ |
| (Signature of Witness) | (Signature of Witness) |
| Address:_____ | Address:_____ |
| _____ | _____ |

**OPTIONAL**

STATE OF COLORADO, County of _____

Subscribed and sworn to or affirmed before me by _____, the declarant, and _____ and _____, witnesses, as the voluntary act and deed of the declarant, this _____ day of _____, in the year _____.

My commission expires: _____
Notary Public

**MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS**

1. I, _____, Declarant, hereby appoint:

_____
Name of Agent

_____
Agent's Home Telephone Number

_____
Agent's Work Telephone Number

_____
Agent's Home Address

as my agent to make health care decisions for me if and when I am unable to make my own health care decisions. This gives my agent the power to consent, to refuse or stop ay health care, treatment, service or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information and sign forms necessary to carry out those decisions.

If the person named as my agent is not available or is unable to act as my agent, then I appoint the follow person(s) to serve in the order listed below:

2. _____ 3. _____
Agent Name Agent Name

_____ _____
Home Telephone # Work Telephone # Home Telephone # Work Telephone #

By this document I intend to create a **Medical Durable Power of Attorney** which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity.

My agent shall make health care decisions as I may direct below or as I make known to him or her in some other way. If I have not expressed a choice about the health care in question, my agent shall base his/her decision on what he/she believes to be in my best interest.

(A) Statement of desires concerning life-prolonging care, treatment, services and procedures:

_____
_____
_____
_____

(B) special provisions and limitations:

_____
_____
_____

BY SIGNING HERE, I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

_____
Signature of person creating Medical Durable Power of Attorney (Declarant) Date

(**Optional But Recommended)**
**Colorado law does not require this instrument to be witnessed; however, it is recommended to obtain the signature of two witnesses or a notary. This is not required by Colorado law but may make this document more acceptable in other states.**

**WITNESS:**
Signature:_____
Home Address:_____
_____
Date:_____

**WITNESS:**
Signature:_____
Home Address:_____
_____
Date:_____

**IMPORTANT INFORMATION ABOUT THE MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS**

Before signing this document, it is very important for you to know and understand these facts:

- This document gives the person you name as your agent the power to make health care decisions if you are unable to do so. (These decisions and powers are not limited to terminal conditions and life support decisions.)

- After you have signed this document, you still have the right to make health care decisions for yourself if you are able to do so.

- You may state in this document any type of treatment that you want to receive or want to avoid. If you want your agent to make decisions about life sustaining treatment, it is best to so state in your **medical durable power of attorney.**

- You have the right to take away the authority of your agent unless you have been determined to be incompetent by a court. If you withdraw (revoke) the authority of your agent, it is recommended that you do so in writing and give copies to all those who received the original document.

- You should not sign this document unless you understand it. You may wish to talk to others or a lawyer.

- The attached **Medical Durable Power of Attorney** form may be used; however, it may not meet your individual needs. Other medical durable power of attorney forms are acceptable according to Colorado law. Be sure the form you sign meets your needs.

- The attached **Medical Durable Power of Attorney** form complies with Colorado law; however, witness, notary and other requirements vary from state to state. If you should move to another state, be sure to check that state's requirements.

Your **medical durable power of attorney** should contain the following information:

- The name, address and telephone number of the person you choose as your agent, and your second choice of agent to act if your first agent is unable to act for you.

- Any instructions about treatment you do or do not wish to receive such as surgery, chemotherapy, or life sustaining treatment such as artificial feeding, kidney dialysis or breathing support, etc.

**Complaints regarding Advanced Directives may be filed with the Colorado Health Department**
**Health Facility Complaint Line: (303) 692-2800 or 1-800-886-7689 ext. 2800 (toll free)**
**Fax: (303) 753-6214.**