



Patient Identification

DURABLE POWER OF ATTORNEY

I, _____, being of sound mind, do hereby designate _____, to serve as my attorney-in-fact for the purpose of making treatment decisions for me (including the withholding or the withdrawal of life-sustaining procedures, nutrition and hydration in the event that I am diagnosed and certifies as having a terminal and irreversible condition) should I become comatose, incompetent, or otherwise mentally or physically incapable of communication.

Principal/Patient Signature Date Time

Address _____

City Parish State

The above named individual is personally known to me is believed to be of sound mind.

Signature of Witness Date Time

Signature of Witness Date Time