Colorado Declaration as to Medical or Surgical Treatment

C.R.S. 15-18-104

I, ____ (name of declarant), 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 my attending physician and one other qualified 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I direct that, in accordance with Colorado law, life-sustaining procedures shall be withdrawn and withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or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 However, I may specifically direct, in accordance with Colorado law, that artificial nourishment be withdrawn or withheld pursuant to the terms of this declaration.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 _________, 20__.

By ____________________________________

Declarant

The foregoing instrument was signed and declared by ____ to be his declaration, in the presence of us, who, in his presence, in the presence of each other, and at his 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.

Dated at ________________________, Colorado, this _________ day of _________, 20__.

____

____

Name and Address

____

____

Name and Address

STATE OF COLORADO

County of __________________________

SUBSCRIBED and sworn to before me by __________________________ , the declarant, and __________________________ and ________________________ , witnesses, as the voluntary act and deed of the declarant this _________ day of _________, 20

My commission expires:___________________________________ ______________________________________

Notary Public

Colorado Medical Durable Power of Attorney for Healthcare

I, ____, hereby appoint:

(name)

____

(name of agent)

____

(home address of agent)

____

(work telephone number of agent) *(home telephone number of agent)*

as my agent to make healthcare decisions for me if and when I unable to make my own healthcare decisions. This gives my agent the power to consent to giving, withholding or stopping any healthcare, treatment, service or diagnostic procedure. My agent also has the authority to talk with healthcare 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 or unwilling to act as my agent, then I appoint the following person(s) to serve in the order listed below:

1. ____

(name of first alternate)

____

(home address)

____

(work telephone number) *(home telephone number)*

2. ____

(name of second alternate)

____

(home address)

____

(work telephone number) *(home telephone number)*

By this document I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own healthcare decisions and shall continue during that incapacity. My agent shall make healthcare 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 healthcare in question, my agent shall base his/her decisions 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.

I sign my name to this form on: ____________________ at: _______________

(*date)*

____

(address)

____

(signature of person creating Medical Durable Power of Attorney)

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that he/she signed or acknowledged this Medical Durable 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 the person appointed as the agent by this document, nor am I the patient's healthcare provider, or an employee of the patient's healthcare provider.

First Witness' Signature ____

Home Address ____

Print Name ____

Date ____

Second Witness' Signature ____

Home Address ____

Print Name ____

Date ____

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