Complete and print.

Reset Form

MAYO CLINIC

Power of Attorney for Healthcare

Mayo Clinic Health System – Wisconsin

Form content retained in medical record.
Route to HIMS Scanning.

TO BE SCANNED

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number (if applicable)
Mayo Clinic Number	

Overview and Instructions

The Power of Attorney for Healthcare allows you to name one or more persons to make your healthcare decisions if you are unable to make them for yourself. The person you appoint is called your **healthcare agent.** Your healthcare agent may make your decisions only when you are unable to do so. It does not allow your healthcare agent to:

- Make your financial or other business decisions.
- Make certain decisions about your mental health treatment in Wisconsin.

It is important that you discuss this document, your views, and your values, with your healthcare agent, so your views and values will be fully respected and understood.

Important Information to Know

1. If your agent is your spouse or domestic partner, and if after signing this document your marriage is annulled, you are divorced or the domestic partnership is terminated, the document is invalid. Please contact your medical provider if needing assistance to create a new document.
2. If you wish to donate your body to medical science after death, contact the closest medical school in your state now and make arrangements through them. Finalizing arrangements for you to donate your body will take time. Here are some places to contact:
    - Mayo Clinic: 507-284-2693
    - University of Wisconsin–Madison Medical School: 608-262-2888
    - Medical College of Wisconsin: 414-955-8261
    - University of Minnesota Medical School – Anatomy Bequest Program: 612-625-1111

    If you donate your body for scientific research, you **cannot** be an organ, tissue, or eye donor.

How to Complete This Document

The Power of Attorney for Healthcare form is divided into four parts:

Part 1: Appointing a Healthcare Agent
Part 2: General Authority of the Healthcare Agent
Part 3: Statement of Desires, Special Provisions, or Limitations
Part 4: Making the Document Legal

After Completing the Power of Attorney for Healthcare

Make copies, keep the original, and give one copy to:

- Your healthcare agent and alternates appointed in the document
- Your physician
- The hospital you would go to in an emergency

Make extra copies to share with others, if you wish (for example: loved ones, VA, clergy, and attorney).

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(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic Number

Personal Information

Name *(First, Middle, Last)*			Birth Date *(mm-dd-yyyy)*	
Home Phone	Work Phone	Mobile Phone		
Street Address	City		State	ZIP Code

Notice to the Person Making This Document

You have the right to make decisions about your healthcare. No healthcare may be given to you over your objection, and necessary healthcare may not be stopped or withheld if you object.

Because your healthcare providers in some cases may not have had the opportunity to establish a long-term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your healthcare.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make healthcare decisions for you if you are unable to make those decisions personally. That person is known as your healthcare agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of healthcare that you do or do not desire, and you may limit the authority of your healthcare agent. If your healthcare agent is unaware of your desires with respect to a particular healthcare decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make healthcare decisions for you. It revokes any prior power of attorney for healthcare that you may have made. If you wish to change your power of attorney for healthcare, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, healthcare provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse or your domestic partner, and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document on file with your physician or other primary care provider.

In Wisconsin, “A power of attorney for healthcare instrument that is in its original form or is a legible photocopy or electronic facsimile copy is presumed to be valid.”

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic Number

PART 1 – Appointing a Healthcare Agent

With this legal form, I am naming who I want to make healthcare choices for me if I am not able. I expect to make my own choices as long as I am able, including stopping, starting, continuing, or refusing medical care. In Wisconsin, unless otherwise specified in this document, if two physicians (or one physician and one psychologist, physician assistant, or nurse practitioner) say that I am not able to make my own decisions, my healthcare agent(s) will make decisions in accordance with my choices. This may be referred to as activation or certification of my Power of Attorney for Healthcare. Activation in other states may vary.

Part A: My Healthcare Agent(s)

When choosing your healthcare agent, choose someone who knows you well, someone you trust, and someone who agrees to respect and honor your choices under stress. This person:

- Must be at least 18 years old.
- Cannot be your medical healthcare physician or work for your healthcare physician (unless he/she is a close relative).

First Choice

Name *(First, Middle, Last)*			Relationship	
Home Phone	Work Phone	Mobile Phone		
Street Address	City		State	ZIP Code

Second Choice If my first healthcare agent is unable or does not want to make decisions for me, my second choice is:

Name *(First, Middle, Last)*			Relationship	
Home Phone	Work Phone	Mobile Phone		
Street Address	City		State	ZIP Code

Third Choice If my second healthcare agent is unable or does not want to make decisions for me, my third choice is:

Name *(First, Middle, Last)*			Relationship	
Home Phone	Work Phone	Mobile Phone		
Street Address	City		State	ZIP Code

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic Number

PART 2 – General Authority of the Healthcare Agent

Upon activation/certification, my healthcare agent is able, but not limited, to:

- Make choices for me about my medical care or services, like tests, medications, and surgery. If treatment has already been started, my healthcare agent can keep it going, change it, or have it stopped depending upon my stated instructions, interpretation of other discussions, or my best interests.
- Review and release my medical records and personal files as needed for my medical care.
- Arrange for my medical care and treatment in any state or county.
- Say which health professionals and organizations may take care of me.
- Admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

Limitations on Mental Health Treatment in Wisconsin

Wisconsin law says my healthcare agent may not admit or commit me to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility, or any mental health treatment facility. My healthcare agent may not consent for me to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures.

Instructions for Completing Part 2

Place your initials (preferred) or a check mark by options offered—"Yes," "No," or "Does not apply." If you do not make a clear choice, the statute in Wisconsin says your choice is considered to be "no." This means that in Wisconsin, if you do not indicate a choice or choose "No," only a court may make such a decision and not your healthcare agent.

1. Long-Term Care

My healthcare agent has the authority, if necessary, to make a decision about admitting me to a nursing home or community-based residential facility for a long-term stay.

A nursing home _____ Yes _____ No

A community-based residential facility (for example, assisted living) _____ Yes _____ No

2. Feeding Tubes and IV Hydration

My healthcare agent has authority to have a feeding tube or IV hydration started, stopped, continued, refused, withheld, or withdrawn from me.

_____ Yes _____ No

If I have checked "Yes" to the above, my healthcare agent may have a feeding tube withheld or withdrawn from me, unless my physician advises that this will cause me pain or will reduce my comfort.

3. Pregnancy

My healthcare agent has authority to make decisions for me if I am pregnant.

_____ Yes _____ No _____ Does not apply

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
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PART 3 – Optional
Statement of Desires, Special Provisions, or Limitations

My healthcare agent shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations that I may list here. If there are conflicts among my known values and goals, I want my agent to make the decision that would best represent my values and preferences.

I have NO INSTRUCTIONS for Part 3. Initials: _____

I am not required to provide any written instructions or make any selections in Part 3. If I choose not to provide any instructions, my healthcare agent will make decisions based on my verbal instructions or what is considered in my best interest.

NOTE: It is important to have on going conversations with my provider(s), healthcare agents, and family about what my preferences and values are regarding medical care for the Stopping of Life-Prolonging Treatment, Pain and Symptom Control, and Cardiopulmonary Resuscitation (CPR). I have the right to guide my own healthcare by writing my desires and values regarding medical care in the following sections.

Stopping Life-Prolonging Treatments

When I consider stopping life-prolonging treatments, this is what is important to me:

Pain and Symptom Control

As I near the end of my life, the following is what is most important to me to manage my pain and other symptoms.

Cardiopulmonary Resuscitation (CPR)

If my heart and breathing stops, known as sudden cardiac death, this is what is important to me, for example, allow natural death, aggressive care:

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic Number

PART 3 – Optional
Statement of Desires, Special Provisions, or Limitations (continued)

When Nearing Death

When I am nearing death and I cannot speak, I want to share with my family and friends the following thoughts and feelings and if time allows, I request my healthcare agent to include the following family and friends.

When I am nearing death, I request that the following rituals, customs, sacraments, ceremonies, or other meaningful supports be provided.

My faith leader/community _____ Contact number_____

When I am nearing death, I request the following measures be taken to help keep me comfortable, for example, favorite music, warm blankets, position in bed:

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic Number

PART 3 – Optional
Statement of Desires, Special Provisions, or Limitations (continued)

Instructions: In each section, initial or check all that apply and/or draw line through statements you do not agree with.

Upon My Death

Donating my organs, tissues, or eyes (anatomical gifts)

_____ I **do** want to donate my eyes, organs and tissues, if possible.

_____ I have indicated this choice on my driver's license or state-issued identification card.

_____ I am registered on my state's online donor registry. (www.DonateLife.net)

_____ I do want to be a donor even if I have not indicated this on my driver's license and/or on the state's online donor registry.

_____ I want to donate **only** my _____.

_____ I **do not** want to donate my eyes, organs and tissues.

Donating my body to scientific research

_____ I understand that if I donate my body for scientific research, I cannot be an organ, tissue, or eye donor.

_____ I **do** want to donate my body for scientific research. I have made arrangements for this with the following institution _____

_____ I understand that selecting the above does not enroll me in a program. I must complete all necessary documentation required by that institution to fully consent and register for their body donation program.

_____ I **do not** want to donate my body for scientific research.

Autopsy

_____ I would accept an autopsy if it can help my blood relatives understand the cause of how I died or it might assist them with their future healthcare decisions.

_____ I would accept an autopsy if it can help the advancement of medicine or medical education.

_____ I do not want an autopsy performed on me, unless required by law.

Other information and requests

Funeral home designation, cremation, or burial plans that I have made are:

_____ By placing my initials (preferred) or a check mark here, I have attached additional documents about my healthcare.

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
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PART 4 – Making the Document Legal

Instructions: Wisconsin residents must have this document signed and dated in the presence of two witnesses. Minnesota or Iowa residents may have document signed and dated in the presence of two witnesses or a notary public (next page.)

I agree with everything in this document. I am doing this willingly.

Patient Signature ▶ Signature Required	Date *(mm-dd-yyyy)*
Printed Name *(First, Middle, Last)*	

I agree with everything in this document and I cannot sign my name. The person named below signed my name in my presence in the section above.

Printed Name *(First, Middle, Last)*	Date *(mm-dd-yyyy)*

Statement of Witnesses

I know this person to be the individual identified in the document. I believe him/her to be of sound mind and at least 18 years of age. I personally witnessed him/her sign this document, and I believe that he/she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years old
- Not a healthcare agent appointed by the person signing this document
- Not related to the person signing this document by blood, marriage, adoption, or not the domestic partner
- Not directly financially responsible for that person's healthcare
- Not a healthcare provider directly serving the person at this time
- Not an employee (other than a social worker or chaplain) of a healthcare facility directly serving the person at this time
- Not aware that I am entitled to or have a claim against the person's estate

Witness 1

Signature ▶ Signature Required		Date *(mm-dd-yyyy)*	
Printed Name *(First, Middle, Last)*		Relationship	
Address	City	State	ZIP Code

Witness 2

Signature ▶ Signature Required		Date *(mm-dd-yyyy)*	
Printed Name *(First, Middle, Last)*		Relationship	
Address	City	State	ZIP Code

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
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Notarization

Iowa and Minnesota Resident Instructions: Residents of Iowa and Minnesota may have the document signed by a notary public authorized in their state, instead of having two witnesses.

Wisconsin Resident Instructions: Notarization of this document is not legal for residents of Wisconsin.

Notary Public

In the State of Minnesota / Iowa (circle one), County of _____

In my presence on (date) _____, (Name) _____

acknowledged his or her signature on this document or acknowledged that he or she authorized the person signing this document to sign on his or her behalf. I am not named as a healthcare agent or alternate healthcare agent in this document.

_____
Signature of Notary

_____
Title of Office (and rank for Military Personnel)

_____
My Commission Expires (date)

Note: Stamp required by law.
If you do not use a stamp, please remember that an embosser does not transfer in making copies.

Notary Stamp

Print