INFORMATION AND INSTRUCTIONS

REGARDING YOUR MASSACHUSETTS HEALTH CARE PROXY

Purpose

A Massachusetts Health Care Proxy is a legal document in which you designate an individual to serve as your health care "Agent" to make health care decisions for you if you become unable to make or communicate those decisions. The health care proxy law, Massachusetts General Laws, Chapter 201D, allows any competent adult (18 years of age or over) to appoint a Health Care Agent. You may use this form if you receive your health care in Massachusetts, even if you do not live in Massachusetts.

Requirements for Agent and Witnesses

You (known as the "Principal") can appoint any competent adult (age 18 or over) as your Agent EXCEPT the administrator, operator, or employee of a health care facility such as a hospital or nursing home where you are a patient or resident UNLESS that person is also related to you by blood, marriage, or adoption. You may also appoint an alternate Agent. Your proxy must be signed in the presence of two competent adult witnesses. The witnesses cannot be the persons named as your Agent or alternate Agent.

Powers of Health Care Agent

Your Agent cannot act for you until a doctor determines, in writing, that you lack the ability to make health care decisions. Acting with your authority, your Agent can make any health care decision that you could, if you were able. If you give your agent full authority to act for you, he or she can consent to or refuse any treatment, including treatment that could keep you alive. Your Agent has the legal right to get any information, including confidential information, necessary to make informed decisions for you.

Your Agent will make health care decisions for you according to your wishes or according to his/her assessment of your wishes, including your religious or moral beliefs. You may wish to talk first with a religious advisor or other people before giving instructions to your Agent. It is very important that you talk with your Agent so that he or she knows what is important to you. If your Agent does not know what your wishes would be in a particular situation, your Agent will decide based on what he or she thinks would be in your best interests. Your Agent's decisions will have the same authority as yours would, if you were able, and will be honored over those of any other person, except for any limitation you yourself made, or except for a Court Order specifically overriding the Proxy.

Use of Original and Copies of Health Care Proxy

You should make at least four photocopies of the Health Care Proxy after you sign it. Keep the original for yourself where it can be found easily (not in your safe deposit box). Give copies to your care providers. Give copies to your Agent and any Alternate Agent. You can give additional copies to family members, religious advisor and/or lawyer, and other people who may be involved in your health care decision making.

Revoking or Changing Your Health Care Proxy

Your Health Care Proxy is revoked when any one of the following four things happens:

1. You sign another Health Care Proxy later on.

2. You legally separate from or divorce your spouse who is named in the Proxy as your Agent.

3. You notify your Agent or a health care provider, orally or in writing, that you want to revoke your Health Care Proxy.

4. You do anything else that clearly shows you want to revoke the Proxy, for example, tearing up or destroying the Proxy, crossing it out, telling other people, etc.

HEALTH CARE PROXY AND DECLARATION OF WISHES REGARDING HEALTH CARE

Caution: This is an important document. It gives the person whom you designate as your "Agent" the authority to make health care decisions on your behalf (including decisions about life-sustaining treatment), and states what your wishes are regarding health care. This document was prepared for use in Massachusetts. Under Massachusetts law, your Agent's authority is effective only if an attending physician determines, in writing, that you lack the capacity to make or to communicate health care decisions. You should consult with your attorney if you have any questions about this form or if you wish to modify it to better match your wishes.

1. Appointment of Agent to Make Health Care Decisions.

I, _____, residing at
(Principal – PRINT your name)

_____
(Street) (City or Town) (State)

appoint as my **Health Care Agent**: _____
(Name of person you choose as Agent)

of _____
(Street) (City or Town) (State)

Agent's telephone number: (h) _____ (w) _____

(OPTIONAL: If my Agent is unwilling or unable to serve, then I appoint as my **Alternate Agent**: _____
(Name of person you choose as Alternate Agent)

of _____.)
(Street) (City or Town) (State) (Phone)

2. Express Powers of My Agent.

My agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers. My Agent's authority becomes effective if an attending physician determines in writing that I lack the capacity to make or to communicate health care decisions.

My Agent is then to have the same authority to make health care decisions I would if I had the capacity to make them EXCEPT **(choose one of the following)**:

□ Option 1--No Limitations

□ Option 2--The following limitations shall apply (write limitations below):

_____

_____

_____

□ Option 3--All treatments authorized by my Agent shall be consistent with my Christian Science beliefs as expressed in Paragraph 3 below.

3. My Wishes Concerning Christian Science Treatments.

NOTE: This Paragraph applies only if you select Option 3 above. If you do not agree with any part of this paragraph, place a line through the word(s) that you do not want and initial the changes in the margin.

In exercising the authority under this Health Care Proxy, my Agent is directed to act consistently with Christian Science as follows:

(a) It is my desire to rely entirely and exclusively upon Christian Science treatment for all my health care needs. Therefore, in lieu of any and all forms of medical treatment, including those thought necessary to sustain my life, I authorize and direct my Agent to arrange for my health care by spiritual means through prayer, exclusively, in accordance with the tenets and practices of Christian Science.

(b) I desire to receive Christian Science treatment from a Christian Science Practitioner whose card appears in the then current edition of *The Christian Science Journal* ("Journal Listed Practitioner"). My choice for a Journal Listed Practitioner would be the following in the order listed: (1) _____;
(2) _____; and (3) _____ . If nursing care is necessary, I prefer to receive it at home from a Christian Science Nurse whose card appears in the then current edition of *The Christian Science Journal* ("Journal Listed Nurse"). My choice for a Journal Listed Nurse would be the following in the order listed:
(1) _____; (2) _____; and
(3) _____ . If a Journal Listed Nurse is not reasonably available, my Agent may arrange for nursing care to be provided by a Christian Scientist who provides nursing

care exclusively in accordance with the tenets and practices of Christian Science. Should I require nursing or convalescent care outside the home, I prefer my Agent to arrange for such care at a Christian Science nursing facility that subscribes exclusively to the tenets and practices of Christian Science and requires its patients to be under the care of a Journal Listed Practitioner. However, I do not wish to be hospitalized or placed in any convalescent or other facility which does not subscribe exclusively to the tenets and practices of Christian Science, except in the extreme circumstance where home care cannot be arranged or is not practical and there is no Christian Science nursing facility available. However, any such facility must agree, if at all possible, to provide nursing care only without medical treatment.

(c) My Agent may, if my Agent determines it appropriate, arrange for me to receive assistance from a medical doctor, optometrist, dentist, or other health care provider, as the case may be, where such assistance consists of care of a more or less mechanical nature, such as the pulling of a tooth, setting of a broken or dislocated bone (except by surgical means), the suturing of wounds, or the provision of eyeglasses. I consider such assistance to be consistent with the tenets and practices of Christian Science. Except as stated above, I do not wish to receive medical life-prolonging care, surgery, medication, blood transfusions, diagnostic testing, shock treatment, or drugs of any kind.

(d) I request that no governmental agency nor any other group or individual intervene to cause medical treatment to be given to me or to cause me to receive medical treatment or be hospitalized against my stated wishes or against the instructions and decisions of my Agent. By arranging for Christian Science treatment for me in lieu of medical treatment, even in a situation which may be deemed life-threatening, my Agent shall not be subject to civil or criminal liability.

(e) If I have elected or obtained health insurance which covers medical treatment, or have in the past sought medical treatment for any condition, this shall not be evidence of any intent on my part to voluntarily seek medical treatment under any other circumstance.

4. Incurable or Terminal Injury or Illness or Coma.

NOTE: This Paragraph is optional. If you do not agree with any portion of this paragraph, place a line through the word(s) that you do not want and initial the changes in the margin.

Notwithstanding the preceding provisions of this document, if a duly-licensed physician has examined me and determined that I have an incurable or terminal injury or illness or that I am in a coma or persistent vegetative state with no reasonable likelihood of regaining consciousness, and that in either case use of life-sustaining procedures would only delay the moment of my death, then it is my wish that (i) life-sustaining procedures be withheld or withdrawn, and (ii) no measures be taken to induce or sustain functioning of my vital systems by chemical, electrical or mechanical means.

5. Reimbursement for Expenses and Indemnification. My Agent shall be entitled to reimbursement for any and all costs and expenses incurred while acting pursuant to this Health Care Proxy except for any actions by my Agent that are determined, by a court of competent jurisdiction, to have been taken in bad faith. This indemnity shall include, but not be limited to, the costs and attorneys' fees incurred by my Agent in bringing, defending or participating in any proceeding with respect to this Health Care Proxy or with respect to the Agent's actions or authority hereunder. To the extent not paid during my lifetime, such expenses shall constitute an obligation of my estate.

6. Appointment of Guardian of My Person. If the appointment of a guardian of my person becomes advisable for any purpose, it is my wish that my Agent, or if my Agent is unwilling or unable to serve, my alternate Agent, be appointed guardian of my person.

PRINCIPAL'S SIGNATURE:

_____

, Principal

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

_____ (Name)

_____ (Street)

_____ (City/Town) (State)

WITNESS STATEMENT: We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document.

In our presence, on this day ___/___/___ (mo/day/yr).

Witness #1 _____ (Signature)

Witness #2 _____ (Signature)

Name (print) _____

Name (print) _____

Address: _____

Address: _____

_____

_____

Commonwealth of Massachusetts
County of _____

Before me, the undersigned notary public, on this _____ day of _____, _____ personally appeared the Principal, _____, and the witnesses, _____ and _____, whose names are signed to the foregoing instrument, each of whom is personally known to me or whose identity was proved to me through a current document issued by a federal or state government agency bearing a photographic image of the signatory's face and signature, and, all of these persons being by me duly sworn; the Principal declared to me and to the witnesses in my presence that [he/she] willingly signed and executed this Health Care Proxy and Declaration of Wishes Regarding Health Care as Principal as [his/her] free and voluntary act for the purposes therein expressed; and each of the witnesses stated to me, in the presence of the Principal, that the witness signed this Health Care Proxy and Declaration of Wishes Regarding Health Care as witness and that to the best of the witness's knowledge the Principal was eighteen years of age or over, of sound mind and under no constraint or undue influence.

_____

(notary seal)