CATHOLIC DECLARATION ON HEALTH CARE DECISION-MAKING

INSTRUCTIONS FOR MY HEALTH CARE

My Catholic faith teaches that human life is a precious gift from God. We are not its owners but its guardians. No one must ever presume to adopt a course of action or inaction that is intended to hasten my death, even if the motive is to alleviate my suffering. Having thought seriously about my beliefs and the principles that the Church teaches about end-of-life decision making, I have set down the following instructions for my care for those who must make decisions for me should I become incompetent — that is, unable to make these decisions for myself.

SPIRITUAL SUPPORT

I request that my family, parish community, and friends support me through prayer and sacrifice and that the sacraments of the Church be made available to me as I prepare for death or face serious illness. I wish to see a Roman Catholic priest and receive the Sacrament of the Sick (formerly called the "last rites"), as well as Confession and Communion.

MEDICAL CARE & TREATMENT

I wish to receive medical care and treatment appropriate to my condition as long as it is useful and offers a reasonable hope of benefit and is not excessively burdensome to me — that is, does not impose serious risk, excessive pain, prohibitive cost, or some other extreme burden. I oppose any act or omission that of itself or by intention will cause my death, even for the purpose of eliminating suffering. I direct that all decisions about my medical treatment and care be made in accord with Catholic moral teachings as contained in such documents as: *Care for Patients in a "Permanent" Vegetative State* (Pope John Paul II, March 20, 2004), *Declaration on Euthanasia* (Congregation for the Doctrine of the Faith, 1980), and *Medical-Treatment Decision-Making: Moral Guidance and Considerations from Catholic Teaching* (Nebraska Catholic Conference, 2020).

FOOD & FLUIDS (NUTRITION AND HYDRATION)

If I am unable (even with assistance) to take food and drink orally, I desire that medically assisted nutrition and hydration (MANH) be provided to me so long as it is capable of sustaining my life. Even if I am in a persistent vegetative state, MANH should be continued. MANH should be discontinued if it is futile (no longer able to sustain my life). MANH should be discontinued if it imposes excessive burdens to me (serious risk, excessive pain, prohibitive cost, or some other extreme burden). MANH should be discontinued if death is both inevitable and so imminent that continuing MANH is judged futile.

PAIN RELIEVING MEDICATION

If my condition includes physical pain, I wish to receive pain-relieving medication in dosages sufficient to manage the pain, even if such dosages make me less alert or responsive, and even if managing my pain in this way is likely to shorten my life. No pain medication should be given to me for the purpose of hastening my death.

IMMINENT DEATH FROM TERMINAL ILLNESS

If my death from a terminal illness is near at hand, I wish to refuse treatment that would only secure a precarious and burdensome prolongation of my life.

PREGNANCY

If I am pregnant, I wish every means to be taken to preserve and nurture the life of my unborn child or children, including the continuation of life-sustaining procedures.

APPOINTMENT OF ATTORNEY-IN-FACT FOR HEALTH CARE

I, _____ , hereby designate and appoint

Name: _____

Address: _____ City/State/Zip: _____

Phone (H): _____ (W): _____ (C): _____

Email: _____

as my attorney-in-fact to make health care decisions for me should I be diagnosed as comatose, incompetent, or otherwise mentally or physically incapable of communication. My attorney-in-fact is to make decisions for me only for the duration of my incompetency. I have carefully discussed my preferences for medical treatment with the above-named attorney-in-fact and I direct my attorney-in-fact to choose on my behalf the appropriate course of treatment or non-treatment that is consistent with the preceding "Instructions for My Health Care." I charge my attorney-in-fact and all those attending me neither to approve nor commit any action or omission which by intent will cause my death. In all decisions regarding my health care, I instruct my attorney-in-fact to act in accordance with Catholic teaching.

If the person named as my attorney-in-fact is not available or is unable to act as my attorney-in-fact, I appoint the following person(s) to act on my behalf.

ALTERNATE ATTORNEY-IN-FACT 1

Name: _____

Address: _____

_____

Phone: _____

ALTERNATE ATTORNEY-IN-FACT 2

Name: _____

Address: _____

_____

Phone: _____

_____ _____

SIGNATURE DATE

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND IT ALLOWS ANOTHER PERSON TO MAKE HEALTH CARE AND MEDICAL TREATMENT DECISIONS FOR ME, INCLUDING LIFE AND DEATH DECISIONS, IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY-IN-FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

_____ _____

SIGNATURE DATE

Note: None of the following may serve as your appointed attorney-in-fact: (1) The attending physician; (2) An employee of the attending physician who is unrelated to the principal by blood, marriage, or adoption ; (3) A person unrelated to the principal by blood, marriage, or adoption who is an owner, operator, or employee of a health care provider in or of which the principal is a patient or resident; or (4) A person unrelated to the principal by blood, marriage, or adoption if, at the time of the proposed designation, he or she is presently serving as an attorney in fact for ten or more principals. (Nebr. Statute 30-3406)

None of the following may serve as a witness to your declaration: Your spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of witnessing, attending physician, attorney in fact, employee of life or health insurance provider for the principal. No more than one witness may be an administrator or employee of a health care provider who is caring for or treating the principal. (Nebr. Statute 30-3405)

DECLARATION OF WITNESS

We declare that the principal is personally known to us, that the principal signed or acknowledged his/her signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney-in-fact by this document.

WITNESS #1 SIGNATURE

DATE

PRINTED NAME

WITNESS #2 SIGNATURE

DATE

PRINTED NAME

ALTERNATIVE: NOTARIZATION

In lieu of two witnesses, the principle's signature may be witnessed by a notary public.

STATE OF NEBRASKA,)
) ss.
COUNTY OF)

On this _____ day of _____ , _____ , before me, a Notary Public, personally came _____ , personally to me known to be the identical person whose name is affixed to the above Durable Power of Attorney for Health Care as principal, and I declare that said person appears to be of sound mind and not under duress or undue influence, that said person acknowledges the execution of the same to be a voluntary act and deed, and that I am not the attorney-in-fact or successor attorney-in-fact appointed by this Durable Power of Attorney for Health Care.

Witness my hand and notarial seal in such county the day and year last above written.

(SEAL)

SIGNATURE of NOTARY PUBLIC

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