MISSOURI
Advance Directive
Planning for Important Health Care Decisions

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It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Holon Inclusive Health System updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care. Health directives may vary by state.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR MISSOURI ADVANCE DIRECTIVE

This packet contains a legal document, a **Missouri Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may fill out Part I, Part II, or both depending on your advance-planning needs. You must fill out Part IV.

Part I, Durable Power of Attorney for Health Care Choices, lets you name someone (an agent, sometimes called an attorney in fact) to make decisions about your health care. Depending on how you fill out your form, this part becomes effective either immediately or when your doctor and one other doctor certify that you are unable by reason of any physical or mental condition to receive and evaluate health care treatment information or to communicate health care decisions. You may choose to have one physician, instead of two, determine whether you are incapacitated (unable to make health care decisions) by initialing the statement in Part I.

Part II is a **Health Care Choices Directive**. This is similar to a living will, although this form—which is based on the form created by the Missouri Attorney General—allows you to make a broader range of decisions than allowed by Missouri's statutory living will. Part II lets you state your wishes about health care in the event that you can no longer speak for yourself. Specifically, Part II allows you to choose specific treatments that you wish to be withheld or withdrawn in the event you have a terminal illness or are persistently unconscious. Part II also allows you to make choices regarding organ donation and includes space for you to add additional instructions and describe your feelings regarding what constitutes an acceptable quality of life. Your Health Care Choices Directive becomes effective when you can no longer make or communicate your health care decisions.

Part III describes the relationship between Part I and Part II.

Part IV contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

COMPLETING YOUR MISSOURI ADVANCE DIRECTIVE

How do I make my Missouri Advance Directive Legal?

In order for Part I to be effective, you must have your signature notarized.

In order for Part II to be effective, you must sign and date your Missouri Advance Directive in the presence of two witnesses who are 18 years or older, neither of whom can be a person signing on your behalf if you are physically unable to sign for yourself.

If you fill out both Part I and Part II, you will need to have your signature both witnessed and notarized.

Who should I pick as my Agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

Your agent may not be your physician or an employee of your physician, or an owner, operator, or employee of the health care facility in which you reside, unless the person is your spouse, parent, child, grandparent, sibling, or grandchild.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Should I add other instructions to my Missouri Advance Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your *Missouri Advance Directive* at any time and in any manner that reflects your intent to revoke. Examples of revocation include tearing your document, orally stating your intent to revoke, or executing a written revocation.

Part II is revoked automatically when you revoke, but revocation of your agent's powers (Part I) becomes effective only once you notify your agent or your physician or treating health care provider. In any event, it is a good idea to tell your agent and your physician or other treating health care provider about your decision to revoke.

Executing a new advance directive that appoints an agent will automatically revoke your agent's authority.

Unless your *Missouri Advance Directive* expressly provides otherwise, if you have appointed your spouse as your agent, filing of any action for divorce or dissolution of your marriage automatically terminates your spouse's authority as your agent.

What other important facts should I know?

Your agent can refuse or withdraw artificial nutrition and hydration on your behalf only if you specifically grant such authority. In order to grant this authority, you must initial the line next to this treatment in Part II.

Before your agent may authorize withdrawal of artificial nutrition or hydration, your physician must:

- Attempt to explain the intent to withdraw artificial nutrition or hydration and the consequences of withdrawal to you and give you an opportunity to refuse withdrawal; or
- Certify that you are comatose or consistently in a condition which makes it impossible for you to understand the intent to withdraw artificial nutrition and hydration and the consequences of withdrawal.

Any directions you give to withhold or withdraw treatments will not be given effect in the event you are pregnant.

Part I. Durable Power of Attorney for Health Care Choices

I, _____, appoint

PRINT YOUR NAME

Name: _____

PRINT YOUR AGENT'S NAME AND ADDRESS

Address: _____

as my agent for health care choices when I am unable to make decisions or communicate my wishes. In the case the person above cannot serve as my agent, or if I am divorced from or legally separated from the agent above, I appoint the person below:

Name: _____

PRINT YOUR ALTERNATE AGENT'S NAME AND ADDRESS

Address: _____

This alternate agent may make health care decisions for me when I am unable to do so or to communicate my wishes.

This durable power of attorney becomes effective when two physicians certify that I am incapacitated and unable to make and communicate health care choices.

You may choose to have one physician, instead of two, determine whether you are incapacitated. If you want to exercise this option — allowing one physician to determine whether you are incapacitated — initial here. _____

INITIAL HERE IF YOU WANT TO ALLOW ONLY ONE PHYSICIAN TO DETERMINE WHETHER YOU ARE INCAPACITATED

By completing this durable power of attorney, I authorize my agent to make all decisions for me regarding my health care. This includes the power to:

IF YOU DON'T WANT YOUR AGENT TO HAVE ANY OF THESE POWERS DRAW A LINE THROUGH THE PROVISION AND INITIAL NEXT TO IT

- Consent, refuse or withdraw consent to artificially supplied nutrition and hydration.
- Make all necessary arrangements for health care on my behalf. This includes admitting me to any hospital, psychiatric treatment facility, hospice, nursing home or other health care facility.
- Hire or fire health care personnel on my behalf.
- Request, receive and review my medical and hospital records.
- Take legal action if necessary to do what I have directed.
- Carry out my wishes regarding autopsy and organ donation, and decide what should be done with my body.

YOUR AGENT MAY HAVE A CLAIM AGAINST YOUR ESTATE FOR REASONABLE EXPENSES THAT ARE PART OF YOUR CARE

My agent under this durable power of attorney will not incur any personal financial liability. The agent also should not be compensated for services performed for me. However, the agent shall be reimbursed for reasonable expenses that are part of my care.

THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY ATTORNEY IN FACT, WHEN EFFECTIVE, SHALL NOT TERMINATE OR BE VOID OR VOIDABLE IF I AM OR BECOME DISABLED OR INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

Part II. Health Care Choices Directive

I want those involved in my health care to understand my wishes if I cannot communicate or make decisions on my own. I make this directive to provide clear and convincing proof of my wishes and instructions about my health care and treatment. If my doctor believes medical treatment will lead to my recovery, I want to have the treatment. I also want to have care and treatment for pain or discomfort even if this treatment might shorten my life, affect my appetite, slow my breathing or be habit-forming.

If I have a terminal illness or condition and there is no reasonable hope I will recover, or if I am persistently unconscious, I direct all of the life-prolonging procedures I have initialed below to be withheld or withdrawn. I direct the following treatments to be withheld or withdrawn: (initial all that apply)

INITIAL ALL TREATMENTS THAT YOU WANT TO BE WITHHELD OR WITHDRAWN IN THE EVENT YOU ARE TERMINALLY ILL OR PERMANENTLY UNCONSCIOUS

_____ Surgery or other invasive procedures

_____ Cardiopulmonary resuscitation (CPR) to restart my heart or breathing

_____ Antibiotics

_____ Dialysis

_____ Mechanical ventilator (respirator)

_____ Artificially supplied nutrition and hydration (including tube feeding)

_____ Chemotherapy

_____ Radiation therapy

_____ All other “life-prolonging” medical treatments or surgeries that are merely intended to keep me alive without reasonable hope of making me better or curing my illness or injury.

Organ Donation Choices (initial only one)

INITIAL YOUR ORGAN DONATION PREFERENCE

_____ I consent to the donation of my organs or tissues. I realize my body may need to be maintained artificially after my death until my organs can be removed.

_____ I refuse to make anatomical gifts of part or all of my body. I prohibit my agent from consenting to such gifts before or after my death.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

I also give the following directions regarding my health care:

_____

_____

_____

_____

_____

_____

Attach extra pages if necessary. Sign and date the attached pages.

OPTIONAL DESCRIBE YOUR IDEA OF AN ACCEPTABLE QUALITY OF LIFE

Optional: Describe what you consider an acceptable quality of life. For example, being able to recognize my loved ones, make decisions, communicate or feed yourself.

_____

_____

_____

_____

_____

_____

Attach extra pages if necessary. Sign and date the attached pages.

Make sure to talk about this directive and your wishes with your agent, your doctors, family, friends and clergy. Give each of them a copy of the directive. Bring a copy with you when you go to a hospital or other health care facility. Keep the original with your important papers.

Part III. Relationship Between Health Care Choices Directive and Durable Power of Attorney for Health Care Choices

This Part is effective only if I have completed Part I and Part II.

As I have executed the health care choices directive and durable power of attorney for health care choices, I trust and encourage my agent to:

- First, follow my wishes as expressed in the directive or otherwise from knowledge about me or having had discussions with me about making choices regarding life-prolonging medical treatment.

- Second, if my agent does not know my wishes for a specific decision, but my agent has evidence of what I might want, my agent can try to figure out how I would decide. This is called substituted judgment and requires my agent imagining himself or herself in my position. My agent should consider my values, religious beliefs, past choices and past statements I have made. The aim is to choose as I probably would choose, even if it is not what my agent would choose for himself or herself.

- Third, if my agent has very little or no knowledge of what I would want, then my agent and the doctors will have to make a decision based on what a reasonable person in the same situation would decide. This is called making decisions in my best interest. I have confidence in my agent's ability to make decisions in my best interest if my agent does not have enough information to follow my preferences or use substituted judgment, and if this is the case, I authorize my agent to make decisions that might even be contrary to my directive in his or her best judgment.

- Finally, if the durable power of attorney for health care choices is determined to be ineffective, or if my agent is unable to serve, the health care choices directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

THIS PART DESCRIBES THE RELATIONSHIP BETWEEN PARTS I AND II IN THE EVENT YOU FILL OUT BOTH PARTS

IF YOU DISAGREE WITH THIS RELATIONSHIP, YOU MAY WANT TO ONLY FILL OUT ONE PART OR TALK TO AN ATTORNEY ABOUT AN ADVANCE DIRECTIVE TAILORED TO YOUR NEEDS

Part IV. Execution

DATE YOUR DOCUMENT

IN WITNESS THEREOF, I have executed this document on this ____ day of _____, in the year of _____.

SIGN HERE AND PRINT YOUR NAME AND ADDRESS

Signature: _____
Print name: _____
Address: _____

If you filled out Part II, you must have your signature witnessed by two people who are at least 18 years of age.

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least 18 years of age.

IF YOU FILLED OUT PART II, YOUR WITNESSES MUST SIGN AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness #1
Signature: _____
Print name: _____
Address: _____

Witness #2
Signature: _____
Print name: _____
Address: _____

If you filled out Part I, you must have your advance directive notarized.

A NOTARY MUST FILL OUT THIS SECTION IF YOU FILLED OUT PART I

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this ____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed.

NOTE: YOU MUST HAVE YOUR DOCUMENT BOTH NOTARIZED AND SIGNED BY TWO WITNESSES IF YOU FILLED OUT PARTS I AND II

IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County

of_____, State of Missouri, the day and year first above written.

_____ _____
Notary public's signature Notary seal

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your *Missouri Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Missouri document.

7. Be aware that your Missouri document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called “prehospital medical care directives” or “do not resuscitate orders” are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**

Go to Complete FAQs & Instructions | Reset or Clear Form | READ BEFORE PRINTING | Print Form

DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND/OR HEALTH CARE DIRECTIVE OF

(Print full name here) _____

(Address, City, State, Zip) _____

PART I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(If you *DO NOT WISH* to name someone to serve as your decision-making Agent, mark an "X" through Part I on pages 1 & 2 and continue on to Part II.)

1. **Selection of Agent**. I, _____, currently a resident of Select County County, Missouri, appoint the following person as my true and lawful attorney-in-fact ("Agent"):

Name: _____

Address: _____

_____

Phone(s): 1st _____ 2nd _____

2. **Alternate Agent**. If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the following persons in the order named below to serve as my alternate Agent and to have the same powers as my Agent:

First Alternate Agent:

Name: _____

Address: _____

_____

Phone(s): 1st _____

2nd _____

Second Alternate Agent:

Name: _____

Address: _____

_____

Phone(s): 1st _____

2nd _____

3. **Durability**. This is a Durable Power of Attorney, and the authority of my Agent, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

4. **Effective Date as to Health Care Decision Making**. This Durable Power of Attorney is effective as to health care decision making when I am incapacitated and unable to make and communicate a health care decision as certified by ***(check one of the following boxes):*** ☐ one physician **OR** ☐ two physicians.

5. **Agent's Powers**. I grant to my Agent full authority as to health care decision making to:

A. Give consent to, prohibit, or withdraw any type of health care, long-term care, hospice or palliative care, medical care, treatment, or procedure, either in my residence or a facility outside of my residence, even if my death may result, including, but not limited to, an out of hospital do-not-resuscitate order, with the following specific authorization ***(initial one of the following boxes to indicate your choice):***

_____ **Initials** I wish to AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

_____ **Initials** OR I DO NOT AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

B. Make all necessary arrangements for health care services on my behalf and to hire and fire medical personnel responsible for my care;

C. Move me into, or out of, any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent;

D. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care;

E. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act as my "personal representative" as defined in the regulations [45 C.F.R. 164.502(g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

6. **Effective Date as to Other Authority.** In addition to the powers set forth above, I authorize effective upon my signature and without the need for a physician's certification of incapacity that my Agent be authorized to have one or more of the following powers ***(initial your desired choices):***

_____ **Initials** Determine what happens to my body after my death (authority for right of sepulcher);

_____ **Initials** Give consent after my death to an autopsy or postmortem examination of my remains;

_____ **Initials** Delegate health care decision-making power to another person ("Delegee") as selected by my Agent, and the Delegee shall be identified in writing by my Agent;

With respect to anatomical gifts of my body or any part (i.e., organs or tissues), please initial your desired choice below:

_____ **Initials** **AUTHORIZATION OF ANATOMICAL GIFTS**. I wish to AUTHORIZE my Agent to make an anatomical gift of my body or part (organ or tissue).

My donations are for the following purposes: (check one)	GIFT SPECIFICATIONS: (check one) I would like to donate
☐ Transplantation ☐ Therapy ☐ Research ☐ Education ☐ All the above	☐ Any needed organs and tissues, as allowed by law. ☐ Any needed organs and tissues as allowed by law, with the following restrictions:

_____ **Initials** **PROHIBITION OF ANATOMICAL GIFTS**. I DO NOT AUTHORIZE my Agent to make an anatomical gift of my body or any part (organ or tissue).

7. **Agent's Financial Liability and Compensation**. My Agent, acting under this Durable Power of Attorney for Health Care, will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions hereof.

PART II. HEALTH CARE DIRECTIVE

(If you *DO NOT WISH* to make a health care directive but only wish to have an Agent make your decisions without the directive, be sure that you have completed Part I on pages 1 & 2, mark an "X" through Part II on pages 2 & 3 and continue to Part III.)

1. I make this HEALTH CARE DIRECTIVE ("Directive") to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment.

2. If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that I have initialed below be withheld or withdrawn.

_____ Initials **artificially supplied nutrition and hydration (including tube feeding of food and water)**

_____ Initials **surgery or other invasive procedures**

_____ Initials **heart-lung resuscitation (CPR)**

_____ Initials **antibiotics**

_____ Initials **dialysis**

_____ Initials **mechanical ventilator (respirator)**

_____ Initials **chemotherapy**

_____ Initials **radiation therapy**

_____ Initials **other procedures specified by me (insert) _____**

_____ Initials **all other "life-prolonging" medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury**

3. However, if my physician believes that any life-prolonging procedure may lead to a recovery significant to me as communicated by me or my Agent to my physician, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

4. If I have already consented to be on the Missouri organ and tissue donor registry or my Agent has authorized the donation of my organs or tissues, I realize it may be necessary to maintain my body artificially after my death until my organs or tissues can be removed.

IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, PART II OF THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE.

PART III. GENERAL PROVISIONS INCLUDED IN THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

1. Relationship Between Durable Power of Attorney for Health Care and Health Care Directive . If I have executed both the Durable Power of Attorney for Health Care and Health Care Directive, I encourage my Agent to:

A. First, follow my choices as expressed in the above Directive or otherwise from knowing me or having had various discussions with me about making decisions regarding life-prolonging procedures.

B. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, *even if it is not what my Agent would choose for himself or herself.*

C. Third, if my Agent has little or no knowledge of choices I would make, then my Agent and the physicians will have to make a decision based on what a reasonable person in the same situation would decide. I have confidence in my Agent's ability to make decisions in my best interest if my Agent does not have enough information to follow my preferences.

D. Finally, if the Durable Power of Attorney for Health Care is determined to be ineffective, or if my Agent is not able to serve, the Health Care Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

2. Protection of Third Parties Who Rely on My Agent. No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

3. Revocation of Prior Durable Power of Attorney for Health Care or Health Care Directive. I revoke any prior living will, declaration or health care directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any prior health care durable power of attorney or any health care terms contained in that other durable power of attorney and intend that this Durable Power for Attorney for Health Care (if completed) and this Health Care Directive (if completed) replace or supplant earlier documents or provisions of earlier documents.

4. Validity. This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

IF YOU HAVE COMPLETED THE ENTIRE DOCUMENT OR ONLY THE DIRECTIVE (PART II), YOU MUST SIGN THIS DOCUMENT IN THE PRESENCE OF TWO WITNESSES.

IN WITNESS WHEREOF, I signed this document on _____(month, date),_____(year).

_____
Signature
Printed Name: _____

WITNESSES: The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen years of age.

Signature	_____	Signature	_____
Print Name	_____	Print Name	_____
Address	_____	Address	_____
	_____		_____

NOTARY ACKNOWLEDGMENT
(Only required if Part I or entire document completed.)

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this _____ day of _____ (month), _____ (year), before me personally appeared _____ _____, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County or City and state aforementioned, on the day and year first above written.

_____
_____, Notary Public
(Name Printed)