

## **SUGGESTIONS FOR PREPARING WILL TO LIVE DURABLE POWER OF ATTORNEY**

*(Please read the document itself before reading this.  
It will help you better understand the suggestions.)*

**YOU ARE NOT REQUIRED TO FILL OUT ANY PART OF THIS "WILL TO LIVE" OR ANY OTHER DOCUMENT SUCH AS A LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE. NO ONE MAY FORCE YOU TO SIGN THIS DOCUMENT OR ANY OTHER OF ITS KIND.**

The Will to Live form starts from the principle that the presumption should be for life. If you sign it without writing any "SPECIAL CONDITIONS," you are giving directions to your health care provider(s) and health care agent<sup>1</sup> to do their best to preserve your life.

Some people may wish to continue certain types of medical treatment when they are terminally ill and in the final stages of life. Others may not.

If you wish to refuse some specific medical treatment, the Will to Live form provides space to do so ("SPECIAL CONDITIONS"). You may make special conditions for your treatment when your death is imminent, meaning you will live no more than a week even if given all available medical treatment; or when you are incurably terminally ill, meaning you will live no more than three months even if given all available medical treatment. There is also space for you to write down special conditions for circumstances you describe yourself.

The important thing for you to remember if you choose to fill out any part of the "SPECIAL CONDITIONS" sections of the Will to Live is that you must be very specific in listing what treatments you do not want. Some examples of how to be specific will be given shortly, or you may ask your physician what types of treatment might be expected in your specific case.

Why is it important to be specific? Because, given the pro-euthanasia views widespread in society and particularly among many (not all) health care providers, there is great danger that a vague description of what you do not want will be misunderstood or distorted so as to deny you treatment that you do want.

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<sup>1</sup> Some states use the terms "attorney in fact," "surrogate," "designee," and "representative" instead of "agent." They are synonymous for purposes of these suggestions.

Many in the medical profession as well as in the courts are now so committed to the quality of life ethic that they take as a given that patients with severe disabilities are better off dead and would prefer not to receive either life-saving measures or nutrition and hydration. So pervasive is this "consensus" that it is accurate to say that in practice it is no longer true that the "presumption is for life" but rather for death. In other words, instead of assuming that a now incompetent patient would want to receive treatment and care in the absence of clear evidence to the contrary, the assumption has virtually become that since any "reasonable" person would want to exercise a "right to die," treatment and care should be withheld or withdrawn unless there is evidence to the contrary. The Will to Live is intended to maximize the chance of providing that evidence.

It is important to remember that you are writing a legal document, not holding a conversation, and not writing a moral textbook. The language you or a religious or moral leader might use in discussing what is and is not moral to refuse is, from a legal standpoint, often much too vague. Therefore, it is subject to misunderstanding or deliberate abuse.

The person you appoint as your health care agent may understand general terms in the same way you do. But remember that the person you appoint may die, or become incapacitated, or simply be unavailable when decisions must be made about your health care. If any of these happens, a court might appoint someone else you don't know in that person's place. Also remember that since the agent has to follow the instructions you write in this form, a health care provider could try to persuade a court that the agent isn't really following your wishes. A court could overrule your agent's insistence on treatment in cases in which the court interprets any vague language you put in your "Will to Live" less protectively than you meant it.

So, for example, do not simply say you don't want "extraordinary treatment." Whatever the value of that language in moral discussions, there is so much debate over what it means legally that it could be interpreted very broadly by a doctor or a court. For instance, it might be interpreted to require starving you to death when you have a disability, even if you are in no danger of death if you are fed.

For the same reason, do not use language rejecting treatment which has a phrase like "excessive pain, expense or other excessive burden." Doctors and courts may have a very different definition of what is "excessive" or a "burden" than you do. Do not use language that rejects treatment that "does not offer a reasonable hope of benefit." "Benefit" is a legally vague term. If you had a significant disability, a health care provider or court might think you would want no medical treatment at all, since many doctors and judges unfortunately believe there is no "benefit" to life with a severe disability.

What sort of language is specific enough if you wish to write exclusions? Here are some examples of things you might--or might not--want to list under one or more of the "Special Conditions" described on the form. Remember that any of these will prevent treatment ONLY under the circumstances--such as when death is imminent--described in the "Special Condition" you list it under. (The examples are not meant to be all inclusive--just samples of the type of thing you might want to write.)

"Cardiopulmonary resuscitation (CPR)." (If you would like CPR in some but not all

circumstances when you are terminally ill, you should try to be still more specific: for example, you might write "CPR if cardiopulmonary arrest has been caused by my terminal illness or a complication of it." This would mean that you would still get CPR if, for example, you were the victim of smoke inhalation in a fire.) "Organ transplants." (Again, you could be still more specific, rejecting, for example, just a "heart transplant.")

"Surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer."

"A treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me."

### **Pain Relief**

Under the "General Presumption for Life," of your Will to Live, you will be given medication necessary to control any pain you may have "as long as the medication is not used in order to cause my death." This means that you may be given pain medication that has the secondary, but unintended, effect of shortening your life. If this is not your wish, you may want to write something like one of the following under the third set of "Special Conditions" (the section for conditions you describe yourself):

"I would like medication to relieve my pain but only to the extent the medication would not seriously threaten to shorten my life." OR

"I would like medication to relieve my pain but only to the extent it is known, to a reasonable medical certainty, that it will not shorten my life."

Think carefully about any special conditions you decide to write in your "Will to Live." You may want to show them to your intended agent and a couple of other people to see if they find them clear and if they mean the same thing to them as they mean to you. Remember that how carefully you write may literally be a matter of life or death--your own.

**AFTER WRITING DOWN YOUR SPECIAL CONDITIONS, IF ANY, YOU SHOULD MARK OUT THE REST OF THE BLANK LINES LEFT ON THE FORM FOR THEM (JUST AS YOU DO AFTER WRITING OUT THE AMOUNT ON A CHECK) TO PREVENT ANY DANGER THAT SOMEBODY OTHER THAN YOU COULD WRITE IN SOMETHING ELSE.**

**IT IS WISE TO REVIEW YOUR WILL TO LIVE PERIODICALLY TO ENSURE THAT IT STILL GIVES THE DIRECTIONS YOU WANT FOLLOWED.**

Robert Powell Center for Medical Ethics  
National Right to Life: [www.nrlc.org](http://www.nrlc.org) ~ (202) 378-8862

## **How to use the Illinois Will to Live Form**

### **SUGGESTIONS AND REQUIREMENTS**

1. This document allows to you to designate (name) a health care agent – someone who will make health care decisions for you whenever you are unable to make them for yourself. It also allows you to give instructions concerning medical treatment decisions that the health care agent must follow.
2. The document must be signed by you, or another at your direction if you are unable to sign for yourself. You must also have a witness sign it.
3. It is helpful to designate successor health care agent(s), to take over if your first choice is unable to serve. There is space on the form for you to designate two successor agents. Neither your attending physician nor any other health care agency may act as your health care agent. However, a person who is not administering health care to you may act as your health care agent even though that person is a licensed physician or otherwise provides health care.
4. Your health care agent’s authority takes effect only when you no longer have the capacity to make and communicate your own health care decisions.
5. The document will remain in effect until you revoke (cancel) it. You may revoke this document (in whole or in part) at any time by burning, obliterating, tearing or otherwise destroying or defacing the document in a manner indicating your intent to revoke. You may also express your intent to revoke orally (in the presence of a witness 18 or older who signs and dates a writing confirming that you stated an intent to revoke), or in a written statement you sign and date.
6. You should tell your doctor about this document. You should also ask your doctor to keep a copy of this document as a part of your medical health record.
7. This type of document has been authorized by the Illinois Powers of Attorney for Health Care Law, Ill. Rev. Stat. §§ 45/4-1 to 45/4-12.
8. You should periodically review your document to be sure it complies with your wishes. Before making changes, be aware that it is possible that the statutes controlling this document have changed since this form was prepared. Contact the Will to Live Project by visiting [www.nrlc.org](http://www.nrlc.org) (Click on “Will to Live”) or an attorney to determine if this form can still be used.
9. If you have any questions about this document, or want assistance in filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit [www.nrlc.org](http://www.nrlc.org)

Form prepared 2001  
Updated 2011

## **NOTICE TO THE INDIVIDUAL SIGNING THE ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE**

PLEASE READ THIS NOTICE CAREFULLY. The form that you will be signing is a legal document. It is governed by the Illinois Power of Attorney Act. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

The purpose of this Power of Attorney is to give your designated "agent" broad powers to make health care decisions for you, including the power to require, consent to, or withdraw treatment for any physical or mental condition, and to admit you or discharge you from any hospital, home, or other institution. You may name successor agents under this form, but you may not name co-agents.

This form does not impose a duty upon your agent to make such health care decisions, so it is important that you select an agent who will agree to do this for you and who will make those decisions as you would wish. It is also important to select an agent whom you trust, since you are giving that agent control over your medical decision-making, including end-of-life decisions. Any agent who does act for you has a duty to act in good faith for your benefit and to use due care, competence, and diligence. He or she must also act in accordance with the law and with the statements in this form. Your agent must keep a record of all significant actions taken as your agent.

Unless you specifically limit the period of time that this Power of Attorney will be in effect, your agent may exercise the powers given to him or her throughout your lifetime, even after you become disabled. A court, however, can take away the powers of your agent if it finds that the agent is not acting properly. You may also revoke this Power of Attorney if you wish.

The Powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in Sections 4-5, 4-6, and 4-10(b) of the Illinois Power of Attorney Act. This form is a part of that law. The "NOTE" paragraphs throughout this form are instructions.

You are not required to sign this Power of Attorney, but it will not take effect without your signature. You should not sign it if you do not understand everything in it, and what your agent will be able to do if you do sign it.

Please put your initials on the following line indicating that you have read this Notice: \_\_\_\_\_

**ILLINOIS STATUTORY SHORT FORM  
POWER OF ATTORNEY FOR HEALTH CARE  
Will to Live Form**

1. I,  
(your name) \_\_\_\_\_  
(your address) \_\_\_\_\_  
\_\_\_\_\_  
(your phone number) \_\_\_\_\_

hereby revoke all prior powers of attorney for health care executed by me and appoint:

(Name of agent) \_\_\_\_\_  
(address of agent) \_\_\_\_\_  
(phone number(s) of agent) \_\_\_\_\_

as my attorney-in-fact (my "agent") to act for me in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue.

A. My agent shall have the same access to my medical records that I have, including the right to disclose the content to others.

B. Effective upon my death, my agent has the full power to make an anatomical gift of the following:

(NOTE: *Initial one. In the event none of the options are initialed, then it shall be concluded that you do not wish to grant your agent any such authority.*)

\_\_\_\_\_ Any organs, tissues, or eyes suitable for transplantation or used for research or education.

\_\_\_\_\_ Specific organs: \_\_\_\_\_

\_\_\_\_\_ I do not grant my agent authority to make any anatomical gifts.

C. I intend for the person named as my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records, including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder. I intend for the person named as my agent to serve as my "personal representative" as that term is defined under HIPAA and regulations thereunder.

(i) The person named as my agent shall have the power to authorize the release of information governed by HIPAA to third parties.

(ii) I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Informational Bureau, Inc., or any other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment for me for such services to give, disclose, and release to the person named as my agent, without restriction, all of my individually identifiable health information and medical records, regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, and mental illness (including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act).

(iii) The authority given to the person named as my agent shall supersede any prior agreement that I may have with my health care providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to the person named as my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider. The authority given to the person named as my agent to serve as my "personal representative" as defined under HIPAA and regulations thereunder and to access my individually identifiable health information or authorize the release of the same to third parties shall take effect immediately, even if I designate in Paragraph 3 of this document that this agency shall otherwise take effect at some future date.

*(NOTE: The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)*

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

*(NOTE: Here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.)*

### **GENERAL PRESUMPTION FOR LIFE**

I direct my health care provider(s) and health care agent(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for

the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care agent to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

—all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy. I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care agent to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my attorney in fact, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.



**WHEN MY DEATH IS IMMINENT**

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:  
**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)

**WHEN I AM TERMINALLY ILL**

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)

**C. OTHER SPECIAL CONDITIONS:**

**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)

**IF I AM PREGNANT**

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care agent(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

\_\_\_\_\_  
Signature of Declarant

*(NOTE: The subject of life-sustaining treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. If you agree with one of these statements, you may initial that statement; but do not initial more than one. These statements serve as guidance for your agent, who shall give careful consideration to the statement you initial when engaging in health care decision-making on your behalf.)*

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed \_\_\_\_\_

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued, unless I am, in the opinion of my attending physician, in accordance with reasonable medical standards at the time of reference, in a state of "permanent unconsciousness" or suffer from an "incurable or irreversible condition" or "terminal condition", as those terms are defined in Section 4-4 of the Illinois Power of Attorney Act. If and when I am in any one of these states or conditions, I want life-sustaining treatment to be withheld or discontinued.

Initialed \_\_\_\_\_

I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards without regard to my condition, the chances I have for recovery or the cost of the procedures.

Initialed \_\_\_\_\_

*(NOTE: This power of attorney may be amended or revoked by you in the manner provided in Section 4-6 of the Illinois Power of Attorney Act. Your agent can act immediately, unless you*

*specify otherwise; but you cannot specify otherwise with respect to your "personal representative" under subparagraph D(iii).)*

3. This power of attorney shall become effective on: \_\_\_\_\_

*(NOTE: Insert a future date or event during your lifetime, such as a court determination of your disability or a written determination by your physician that you are incapacitated, when you want this power to first take effect.)*

*(NOTE: If you do not amend or revoke this power, or if you do not specify a specific ending date in paragraph 4, it will remain in effect until your death; except that your agent will still have the authority to donate your organs, authorize an autopsy, and dispose of your remains after your death, if you grant that authority to your agent.)*

4. This power of attorney shall terminate on: \_\_\_\_\_

*(NOTE: Insert a future date or event, such as a court determination that you are not under a legal disability or a written determination by your physician that you are not incapacitated, if you want this power to terminate prior to your death.)*

*(NOTE: You cannot use this form to name co-agents. If you wish to name successor agents, insert the names and addresses of the successors in paragraph 5.)*

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

A. First Successor Agent

(successor agent's name) \_\_\_\_\_

(successor agent's address) \_\_\_\_\_

\_\_\_\_\_  
(successor agent's phone number) \_\_\_\_\_

B. Second Successor Agent

(second successor agent's name) \_\_\_\_\_

(second successor agent's address) \_\_\_\_\_

\_\_\_\_\_  
(second successor agent's phone number) \_\_\_\_\_

For the purposes of paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

*(NOTE: If you wish to, you may name your agent as guardian of your person if a court decides*

*that one should be appointed. To do this, retain paragraph 6, and the court will appoint your agent if the court finds that this appointment will serve your best interests and welfare. Strike out paragraph 6 if you do not want your agent to act as guardian.)*

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

(Signature) \_\_\_\_\_

(Date) \_\_\_\_\_

**WITNESS**

The principal has had an opportunity to review the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. The undersigned witness certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.

Witness Signature: \_\_\_\_\_

Residing at: \_\_\_\_\_  
\_\_\_\_\_

*(NOTE: You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.)*

Specimen signatures of agent (and successors)

I certify that the signatures of my agent (and successors) are correct.

\_\_\_\_\_  
(agent)

\_\_\_\_\_  
(principal)

\_\_\_\_\_  
(successor agent)

\_\_\_\_\_  
(principal)

\_\_\_\_\_  
(successor agent)

\_\_\_\_\_  
(principal)

*(NOTE: The name, address, and phone number of the person preparing this form or who assisted the principal in completing this form is optional.)*

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(name of preparer)

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(address)

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(phone)

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