

CATHOLIC ADVANCE CARE PLAN/HEALTH CARE POWER OF ATTORNEY

I, _____, pursuant to the Tennessee Health Care Decisions Act (Tenn. Code Ann. Section 68-11-1801 et seq.), hereby reaffirm my belief in the Catholic faith and our profession of one God whose love is shown in Christ Jesus, Savior of the world, "the way, the truth and the life" (John 14:6). In his death on the cross and resurrection to new life, Jesus has conquered the ultimate sting of sin and death. Within that faith, I choose to follow the moral teachings of the Catholic Church.

Agent/Attorney in Fact: With my Declaration of Faith in mind, I appoint the following individual as my Agent/Attorney in Fact to make my health care decisions if I cannot make decisions for myself, including end-of-life decisions, based on his or her conscience and the teachings of the Catholic Church:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent/Attorney in Fact: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____
Address: _____

This Advance Care Plan/Health Care Power of Attorney is specifically given pursuant to the provisions of the Tennessee Health Care Decisions Act (Tenn. Code Ann. Section 68-11-1801 et seq.) and the Durable Power of Attorney for Health Care Act (Tenn. Code Ann. Section 34-6-201 et seq.). Accordingly, all acts done by my Agent/Attorney in Fact pursuant to this document shall have the same effect and inure for my benefit and bind me and my successors in interest as if I personally performed said acts. In addition, all acts done by my Agent/Attorney in Fact pursuant to this document, during any period of my disability or incapacity, shall have the same effect and inure to my benefit and bind me and my successors in interest as if I were competent and not disabled.

Revocation of Prior Documents: This document revokes all Powers of Attorney for health care and Living Wills previously executed.

End-of-Life Decisions: If I am suffering from an illness or condition from which my attending physician has determined that there is no reasonable medical expectation of recovery, then my Agent/Attorney in Fact is specifically authorized to make any and all medical decisions necessary to comply with my wishes to honor my Catholic faith including withholding and withdrawing all medical care, excepting only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care or to alleviate pain. My specific wishes are as follows:

If my heart stops beating or I stop breathing,

____ I wish to pass on naturally in peace and dignity without resuscitative efforts (No CPR)

OR

____ I wish to have resuscitative efforts performed (CPR)

If there is no reasonable expectation of recovery, or if it is deemed to be excessively burdensome,

____ I do not wish to have artificial hydration and nutrition given to me.

OR

____ I wish to have artificial hydration and nutrition given to me.

If there is no reasonable expectation of recovery, or if it is deemed to be excessively burdensome,

____ I wish to have all medical care directed at alleviating pain and providing comfort.

OR

____ I wish to have all medical procedures deemed necessary to attempt to cure the illness while ensuring my comfort during those procedures.

____ As an alternative to all of the above choices, I defer to the conscience of my Agent/Attorney in Fact with regard to all the above procedures and /or treatments.

(initial decisions above)

