STATE OF NEW YORK

DURABLE POWER OF ATTORNEY FOR MEDICAL TREATMENT

I, , having an address at , appoint , having an address at as my attorney-in-fact to carry out my specific and general instructions and wishes with respect to and all medical treatment.

In the event the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint having an address at

I have made known to my attorney-in-fact and authorize him/her to express and carry out my specific and general instructions and wishes with respect to medical treatment, including my desires on the subject of withholding or withdrawing all forms of life-sustaining medical treatment, including tubal feedings and medication.

This power of attorney shall become effective when I can no longer make my own medical decisions and shall not be affected by subsequent disability or incompetence. The determination of whether I can make my own medical decisions is to be made by my attorney-in-fact, or if he or she is unable, unwilling or unavailable to act, by my alternate attorney-in-fact.

IN WITNESS WHEREOF, I have set my hand this day of , 20 .

_____
principal

The above principal, who appears to be of sound mind and under no duress, voluntarily signed this instrument in our presence. I am not the person appointed as attorney-in-fact or alternate attorney-in-fact by this document.

_____	_____
Witness	Address
_____	_____
Witness	Address

STATE OF NEW YORK
COUNTY OF , ss:

On the day of , in the year 20 , before me the undersigned, personally appeared personally known to me or proved to me on the basis of satisfactory evidence, to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that (he) (she) (they) executed the same in (his) (her) (their) capacity(y)(ies), and that by (his) (her) (their) signature(s) on the instrument, the individual(s) or the person upon behalf of which the individual(s) acted, executed the instrument.

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Notary Public