ACCEPTANCE OF PATIENT ADVOCATE

I agree to be the Patient Advocate (PT.AD.) for ______________________________ (called "the patient" in this document). I accept the patient's designation of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the patient as indicated in the Durable Power of Attorney, in other written instructions of the patient, and as we have discussed verbally.

I also understand and agree to the following conditions:

a. This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.

b. A PT.AD. shall not exercise powers concerning the patient's care, custody, and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised on her or his own behalf.

c. This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant, that would result in the pregnant patient's death.

d. A PT.AD. may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the PT.AD. is authorized to make such a decision which could or would allow the patient's death.

e. A PT.AD. shall not receive compensation for the performance of her/his authority, rights, and responsibilities, but a PT.AD. may be reimbursed for actual and necessary expenses incurred in the performance of her/his authority, rights and responsibilities.

f. A PT.AD. shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient, and shall act in the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interest.

g. A patient may revoke her/his designation at any time and in any manner sufficient to communicate an intent to revoke.

h. A PT.AD. may revoke her/his acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

If I am unavailable to act, after reasonable effort to contact me, I delegate my authority to the person(s) the patient has designated as successor Patient Advocate in the order designated. The successor PT.AD. is authorized to act until I become available to act.

ACCEPTANCE OF PATIENT ADVOCATE DESIGNATION PAGE 1 OF 2	Patient Identification Name: Number: D.O.B.:

PATIENT ADVOCATE:

Sign Name: ______________________ Print Name: ______________________

Address: ____

Home Telephone: ( ) ______________ Work Telephone: ( ) ______________

SUCCESSOR PATIENT ADVOCATE:

Sign Name: ______________________ Print Name: ______________________

Address: ____

Home Telephone: ( ) ______________ Work Telephone: ( ) ______________

SUCCESSOR PATIENT ADVOCATE:

Sign Name: ______________________ Print Name: ______________________

Address: ____

Home Telephone: ( ) ______________ Work Telephone: ( ) ______________

ACCEPTANCE OF PATIENT ADVOCATE DESIGNATION PAGE 2 OF 2	Patient Identification Name: Number: D.O.B.:

DISTRIBUTION: White – Health Record; Canary – Institutional Record; Pink – Prisoner