POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

Notice: The powers granted by this document are broad and sweeping. They are defined in Connecticut Statutory Short Form Power of Attorney Act, sections 1-42 to 1-56, inclusive, of the general statutes, which expressly permits the use of any other different form of power of attorney desired by the parties concerned.

KNOW ALL MEN BY THESE PRESENTS, Which are intended to constitute a GENERAL POWER OF ATTORNEY pursuant to Connecticut Statutory Short Form Power of Attorney Act:

That I: ______________________________ do hereby appoint: _____________________

____ my, attorney(s)-in-fact TO ACT: *

*If more than one agent is designated and the principal wishes each agent alone to be able to exercise the power conferred, insert in this blank the word 'severally'. Failure to make any insertion or the insertion of the word 'jointly' shall require the agents to act jointly.

FIRST, In my name, place and stead in any way which I myself could do, if I were personally present, with respect to <u>health care decisions</u> as defined in the Connecticut Statutory Short Form Power of Attorney Act to the extent that I am permitted by law to act through an agent:

SECOND, With full and unqualified authority to delegate any all of the foregoing powers to any person or persons whom my attorney(s)-in-fact shall select.

THIRD, Hereby ratifying and confirming all that said attorney(s) or substitute(s) do or cause to be done.

FOURTH, This Power of Attorney shall not be affected by my subsequent disability or incompetence of the principal herein named.

FIFTH, I hereby agree that any third party receiving a copy or facsimile of this executed instrument may act in reliance thereon and that revocation or termination of this power of attorney shall be ineffective as to such third party unless and until actual notice or knowledge thereof shall have been received by such third party, and I, for myself and my heirs, assigns and legal representatives, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of reliance on such copy of this instrument.

I hereby declare that, with respect to the powers conferred by this executed instrument, any and all such powers which may have been conferred in a previously executed instrument or instruments are hereby revoked.

I further instruct that, upon being informed that my attending physician has determined that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my attorney-in-fact to execute an affidavit stating said determination has occurred.

In Witness Whereof, I have hereunto signed my name and affixed my seal this _____ day of ________________________, 200____.

Signed, sealed and delivered in presence of:

____
Signature of Principal

x_____________________________	x_____________________________
(Witness)	(Witness)
_____________________________	_____________________________
(Number and Street)	(Number and Street)
x_____________________________	_____________________________
(City, State and Zip Code)	(City, State and Zip Code)

STATE OF CONNECTICUT)
: ss. ________________________
(Town)
COUNTY OF _________________________)

The foregoing POWER OF ATTORNEY was acknowledged before me this day _______ of ______________________, 200____, by ______________________________________.
(Principal)

____
Commissioner of the Superior Court
Notary Public
My Commission expires:____________