Rhode Island Living Will Declaration

R.I. Gen. Laws § 23-4.11-3

I, _____, being of sound mind willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, so hereby declare:
If I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

This authorization ☐ includes
☐ does not include
the withholding or withdrawal of artificial feeding. *(check only one box above)*

Signed this _____ day of _____, _____.

_____
Signature of Declarant

_____
Address

The Declarant is personally known to me and voluntarily signed this document in my presence. I am not related to the Declarant by blood or marriage.

_____ _____
Witness Witness

_____ _____
Address Address

Rhode Island Durable Power of Attorney for Healthcare

1. DESIGNATION OF HEALTHCARE AGENT.

I, _____,
(name)

_____
(address)

do hereby designate and appoint: _____
(name of agent)

_____
(address)

_____ _____
(home telephone number) (work telephone number)

(insert name, address, and telephone number of one individual only as your agent to make healthcare decisions for you. None of the following may be designated as your agent: (1) your treating healthcare provider, (2) a nonrelative employee of your treating healthcare provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility.)

as my attorney in fact (agent) to make healthcare decisions for me as authorized in this document. For the purposes of t his document, "healthcare decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTHCARE. By this document I intend to create a durable power of attorney for healthcare.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make healthcare decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make healthcare decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures. *(If you want to limit the authority of your agent to make healthcare decisions for you, you can state the limitations in paragraph 4 ["Statement of Desires, Special Provisions, and Limitations"] below. You can indicate your desires by including a statement of your desires in the same paragraph.)*

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. *(Your agent must make healthcare decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your healthcare. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad power to make healthcare decisions for you, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for healthcare, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

a. Statement of desires concerning life-prolonging care, treatment, services, and procedures:

b. Additional statements of desires, special provisions, and limitations regarding healthcare decisions:

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.) If you wish to make a gift of any bodily organ you may do so pursuant to the Uniform Anatomical Gift Act.

☐ I want to be an organ donor. In the event of my death I request that my agent inform my family/next of kin of my desires to be an

organ and tissue donor if possible. My wishes are indicated below.
I wish to give:
☐ any needed organs/ tissues: or
☐ only the following organs/tissues:

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.
Subject to any limitations in this document, my agent has the power and authority to do all of the following:
a. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.
b. Execute on my behalf any releases or other documents that may be required in order to obtain this information.
c. Consent to the disclosure of this information. *(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ["Statement of desires, special provisions, and limitations"] above.)*

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the healthcare decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:
a. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."
b. Any necessary waiver or release from liability required by a hospital or physician.

7. DURATION. *(Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)*
This durable power of attorney for healthcare expires on

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

8. DESIGNATION OF ALTERNATE AGENTS. *(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same healthcare decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)*
If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a healthcare decision for me or loses the mental capacity to make healthcare decisions for me, or if I revoke that person's appointment or authority to act as my agent to make healthcare decisions for me, then I designate and appoint the
following persons to serve as my agent to make healthcare decisions for me as authorized in this document, such persons to serve in the order listed below:
A. First Alternate Agent: _____

_____
(Insert name, address, and telephone number of first alternate agent.)

B. Second Alternate Agent: _____

_____
(Insert name, address, and telephone number of second alternate agent.)

9. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for healthcare.

DATE AND SIGNATURE OF PRINCIPAL
(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney For Healthcare on _____
(date)
at _____, _____.
(city) *(state)*

_____
(you sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO (2) QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

(This document must be witnessed by two (2) qualified adult witnesses. None of the following may be used as a witness:
1. A person you designate as your agent or alternate agent,
2. A healthcare provider,
3. An employee of a healthcare provider,
4. The operator of a community care facility,
5. An employee of an operator of a community care facility.
At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a healthcare provider; an employee of a healthcare provider; the operator of a community care facility; nor an employee of an operator of a community care facility.

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature:_____

Print Name: _____

Signature:_____

Print Name: _____

HALT

AN ORGANIZATION OF
AMERICANS FOR LEGAL REFORM
Email: HALT@HALT.org
Phone: 1-888-FOR-HALT
www.halt.org
(202) 887-8255
Fax: (202) 887-9699
1612 K Street, NW Suite 510
Washington, DC 20006