ADDENDUM
WISCONSIN POWER OF ATTORNEY FOR HEALTH CARE

PART I: CREATION OF AN ADDENDUM TO THE POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT

The following are specific desires, provisions or limitations that I, ____ wish to state regarding any and all health care decisions made on my behalf. This document is an ADDENDUM to my POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT, pursuant to Wisconsin Statutes Section 155.30, and is incorporated into the STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS found on page________ of my POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT. I hereby reaffirm all provisions of this Wisconsin POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT unless specifically provided herein. In the event there is any ambiguity between the Wisconsin POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT and this ADDENDUM, this ADDENDUM is controlling.

My health care agent must make health care decisions for me based on the instructions I provide in this ADDENDUM. He or she must act in my best interest consistent with the principles I have stated in this document, or if unstated within this ADDENDUM, in accord with any wishes I have made known to him or her.

If I ever have incapacity and my health care agent is not available to provide instruction regarding my health care decisions, my health care providers, others assisting with my health care, and my family shall make health care decisions for me based on the desires, special provisions or limitations contained herein as incorporated into my POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT.

I have discussed the meanings of the words used in the POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT and in this ADDENDUM with my health care agent, and my agent’s interpretation of them is definitive.

PART II: HEALTH CARE INSTRUCTIONS

If I ever have incapacity, these are my desires, provisions and limitations regarding my health care. As such, they should be followed in a manner that ensures proportionate means are used to preserve my life. Most of what I state here is general in nature, since I cannot anticipate all the possible circumstances of a future illness. If I have not given specific instructions, then my health care agent must make decisions consistent with my wishes and beliefs, in accordance with the principles set forth below.

DESIRES, PROVISIONS AND LIMITATIONS FOR MY HEALTH CARE

I ask that decisions be thus made respectful of, and according to, the following principles:

1. *Ordinary* or *proportionate* means shall be used to preserve my life. Proportionate means are those that offer a reasonable hope of benefit, are reasonably expected to prolong my life, do not entail an excessive burden or impose excessive expense on my family or community, and do not cause significant physical discomfort.

2. Medical treatments that are extraordinary or *disproportionate* means of preserving my life may be withdrawn or avoided. Disproportionate means are those that do not offer a reasonable hope of benefit, are not reasonably expected to prolong my life, entail an excessive burden or impose excessive expense on my family or the community, or cause significant physical discomfort.

3. In principle, there is an obligation to provide me with food and water, including medically assisted nutrition and hydration if I cannot take food orally. This obligation extends to chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") where I am reasonably expected to live indefinitely if given such care. Medically assisted nutrition and hydration become optional when they cannot reasonably be expected to prolong life, or when they would be excessively burdensome for me, or would cause significant physical discomfort, for example resulting from complications in the use of the means employed. For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort. Financial burden should only be considered when the administration of this means cannot be expected to prolong my life or lessen significant physical discomfort.

4. I should not be deprived of consciousness without a compelling reason.

5. I oppose suicide and euthanasia. Treatment or support must not be provided or withheld for the purpose of causing my death.

6. I desire the use of medication or procedures necessary for my comfort. Medicines capable of alleviating or suppressing pain may be given to me, even if this therapy <u>may indirectly</u> shorten my life. However, I do not wish to receive such treatment when given for the purpose/intent of hastening my death.

7. If my death is imminent, I desire that those treatments which maintain a precarious and burdensome prolongation of my life be withdrawn or avoided, unless those responsible for my care judge that there are special and significant reasons why I should continue to receive such treatment.

8. I also desire that the following be adhered to regarding my health care decisions:

This ADDENDUM, as incorporated into my POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT, completes my health care directive.

PART III: MAKING THE DOCUMENT LEGAL

(Wisconsin residents must have this document signed and dated in the presence of two witnesses. The principal and the witnesses all must sign the document at the same time.)

SIGNATURE OF PRINCIPAL

(Person creating the ADDENDUM to the POWER OF ATTORNEY FOR HEALTH CARE)

I am thinking clearly; I agree with everything that is written in this document and I have made this document willingly.

______________________________	________________
Signature	**Date**

(The signing of this document by the principal incorporates this ADDENDUM into the POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT per Wisconsin Statute Section 155.30.)

STATEMENT OF WITNESSES

I know this person to be the individual identified in this ADDENDUM to the POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not a health care agent appointed by the person signing this document.
- Not related to the person signing this document by blood, marriage or adoption.
- Not directly financially responsible for this person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against this person's estate.

Witness #1 Date _____________	**Witness #2** Date ______________
______________________________	______________________________
Signature	Signature
______________________________	______________________________
Print Name	Print Name
______________________________	______________________________
Address	Address

After you complete the ADDENDUM, make copies to be distributed with the POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT as follows:

- One copy for yourself.
- One copy for the health care agent and alternates appointed in the POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT.
- One copy to share and discuss with your physician.
- One copy for your record at the hospital where you would go in an emergency.
- Extra copies to share with others if you wish (loved ones, your clergy, and your attorney).

Note: A photo or fax copy is as legally valid as an original.

Copies of this document have been given to:

1. ____
2. ____
3. ____
4. ____
5. ____

If a new document is created, all previous copies should be replaced with a copy of the new one.

Revised August 2014