Michigan Living Will

Although 48 states have statutes giving living wills legal force, Michigan has not passed such a law. However, based on a Michigan court decision, there is an argument living wills are binding in this state. No one, however, can provide absolute assurance your wishes will be honored.

I, _____, am of sound mind, and I voluntarily make this decision.

If I become terminally ill or permanently unconscious as determined by my doctor and at least one other doctor, and if I am unable to participate in decisions regarding my medical care, I intend this declaration to be honored as the expression of my legal right to authorize or refuse medical treatment.

My desires concerning medical treatment are:

My family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for following my wishes as expressed in this declaration.

I may change my mind at any time by communicating in any manner that this declaration does not reflect my wishes.

Photocopies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and accept its consequences.

Dated: _____ Signed: _____
(Your Signature)

_____

_____
(Address)

STATEMENT OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____
(Print Name) (Signature of Witness)

_____ _____

_____ _____
(Address)

_____ _____
(Print Name) (Signature of Witness)

_____ _____

_____ _____
(Address)

Michigan Designation of Patient Advocate for Healthcare

I _____
(name)

_____
(address)

am of sound mind, and I voluntarily make this designation.

I designate _____
(name of patient advocate)

residing at _____
(address)

_____
(home phone number) *(work phone number)*

as my patient advocate to make care, custody, or medical treatment decisions for me only when I become unable to participate in medical treatment decisions. The determination of when I am unable to participate in medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist. If the first individual is unable, unwilling, or unavailable to serve as my patient advocate, then I designate:

_____
(name of successor agent)

residing at _____
(address)

_____
(home phone number) *(work phone number)*

to serve as my patient advocate.

I authorize my patient advocate to decide to withhold or withdraw medical treatment which could or would allow me to die. I am fully aware that such a decision could or would lead to my death. In making decisions for me, my patient advocate shall be guided by my wishes, whether expressed orally, in a living will, or in this designation. If my wishes as to a particular situation have not been expressed, my patient advocate shall be guided by his or her best judgment of my probable decision, given the benefits, burdens and consequences of the decision, even if my death, or the chance of my death, is one consequence.

My patient advocate shall have the same authority to make care, custody and medical treatment decisions as I would if I had the capacity to make them EXCEPT *(here list the limitations, if any, you wish to place on your patient advocate's authority)*:

This designation of patient advocate shall not be affected by my disability or incapacity. This designation of patient advocate is governed by Michigan law, although I request that it be honored in any state in which I may be found. I reserve the power to revoke this designation at any time by communicating my intent to revoke it in any manner in which I am able to communicate.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I voluntarily sign this designation of patient advocate after careful consideration. I accept its meaning and I accept its consequences.

_____
(your signature)

_____
(date)

_____
(your street address)

_____
(city, Michigan, zip code)

Statement of Witnesses

We sign below as witnesses. This designation was signed in our presence. The designator appears to be of sound mind, and to be making this designation voluntarily, and under no duress, fraud, or undue influence.

Witness 1: _____

(signature)

_____

(print or type full name)

_____

(address)

Witness 2: _____

(signature)

_____

(print or type full name)

_____

(address)

Acceptance by Patient Advocate and Successor Advocate (If Any)

(A) This designation shall not become effective unless the patient is unable to participate in treatment decisions.
(B) A patient advocate 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 his or her 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 patient's death.
(D) A patient advocate 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 patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.
(E) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in performance of his or her authority, rights, and responsibilities.
(F) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with 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 interests.
(G) A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
(H) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.
(I) A patient admitted to a health facility or agency has the rights enumerated in *Section 20201* of the *Public Health Code, Act No. 368* of the Public Acts of 1978, being *section 333.20201* of the *Michigan Compiled Laws*.
(J) A patient advocate may choose to have the patient placed under hospice care.

I understand the above conditions and I accept the designation as patient advocate for _____.

(name of principal)

Dated _____ Signed _____

I understand the above conditions and I accept the designation of successor patient advocate for _____.

(name of principal)

Dated _____ Signed _____

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