ROMAN CATHOLIC HEALTH CARE PROXY

1. APPOINTMENT OF HEALTH CARE AGENT AND ALTERNATE

I, _____, residing at _____, Massachusetts,
(name of principal) (street) (city)

appoint _____,
(name of Health Care Agent) (area code and telephone number)

residing at _____, as my Health Care
(street) (city/state)

Agent ("Agent") to make health care decisions for me as authorized in this Health Care Proxy according to Chapter 201D of the General Laws of Massachusetts, including any future amendments ("Chapter 201D"). Capitalized terms used and not defined in this Health Care Proxy have the meaning specified in Chapter 201D.

If for any reason _____, is unavailable, unwilling, incompetent, or
(name of Health Care Agent)

otherwise disqualified under Chapter 201D to act as my Agent and is not expected to become available, willing, competent or qualified to make a timely decision given my medical circumstances, I appoint

_____, residing at _____,
(name of alternate agent) (area code & telephone) (street)

_____, as my Agent.
(city/state)

2. WHEN MY AGENT'S AUTHORITY TO MAKE HEALTH CARE DECISIONS ON MY BEHALF BECOMES EFFECTIVE

My Agent is authorized to act on my behalf only if and when my Attending Physician determines, as provided in Section 6 of Chapter 201D, that I lack the Capacity to Make Health Care Decisions or to communicate my decisions. A notice that such a determination has been made must be given orally and in writing (a) to me, if there is any indication that I could comprehend the notice, (b) to my Agent and (c) if I am in or transferred from a mental health Facility, to the director of the Facility.

My Agent's authority will end if and when my Attending Physician determines that I have regained the Capacity to Make Health Care Decisions and will resume if it is again determined that I lack such capacity.

Notwithstanding my Attending Physician's determination that I lack the Capacity to Make Health Care Decisions, if I object to any decision made by my Agent, my decision will prevail unless a court of competent jurisdiction determines that I lack the Capacity to Make Health Care Decisions.

3. SCOPE OF MY AGENT'S AUTHORITY

My Agent is authorized to make any and all Health Care decisions for me that I could make on my own behalf, including decisions about life-sustaining treatment, subject to any limitations described herein. My Agent may make Health Care decisions for me (a) only after consultation with my Health Care Providers and consideration of acceptable medical alternatives regarding diagnosis, prognosis, treatments and their side effects, and (b) according to my Agent's assessment of my wishes as stated in this Health Care Proxy, or as otherwise known to my Agent, including my religious and moral beliefs or, if my wishes are not known, according to what my Agent determines to be in my best interest.

I also authorize my Agent

(a) to receive any medical information regarding me or my Health Care, including any confidential medical information that I would be entitled to receive, and to disclose the information to others;

(b) to arrange my admission to or discharge from any Facility, even if against medical advice;

(c) to contract for any Health Care for me at my expense, without incurring personal liability for the payment of any Health Care;

(d) to employ and discharge Health Care Providers and related support personnel; and

(e) to do all things necessary to carry out the intent of this Health Care Proxy, including granting any waiver or release from liability required by a Health Care Provider, signing any documents relating to a refusal of treatment and pursuing any legal action in my name and at my expense to force compliance with my wishes as determined by my Agent.

(f) _____

(Please list other specific authorizations here)

_____.

4. MY WISHES REGARDING HEALTHCARE DECISIONS AND EXPRESS LIMITATIONS ON MY AGENT'S AUTHORITY

I direct that my Agent make Health Care decisions for me which are consistent with authentic Roman Catholic ethical, moral and religious principles and based upon my profound respect for life and my belief in eternal life. I direct my Attending Physician(s) and the Facility where I am a patient, provide me with proper medical treatment and care including, but not limited to:

(a) appropriate pain relieving medicine in an amount to alleviate or suppress my pain, but not calculated specifically to cause or hasten my death;

(b) food and water to sustain my life, including when provided by artificial means, and including when I am diagnosed as having a chronic and presumably irreversible disabling condition—(sometimes described as a "persistent vegetative state")—and I am reasonably expected to live if given food and water; however, my Health Care Agent may consent to discontinuing food and water when they no longer provide reasonable hope of prolonging my life or relieving my suffering, or they may be discontinued when their provision or the means of providing them causes me significant discomfort or imposes other excessive burdens on me or my family

(c) standard comfort care appropriate for any patient suffering from illness, injury or disease; and

(d) [if I am pregnant] treatment or care necessary to benefit my unborn child, even if such treatment or care shortens or prolongs my life when I am diagnosed as having a terminal condition];

(e) _____

(Please list other wishes here)

_____.

Notwithstanding the above, I also specifically limit my Agent's authority as follows (if the following space is not filled in, then there are no express limitations):

_____

_____.

5. SACRAMENTS AND SPIRITUAL CARE

I direct my Health Care Agent, in consultation with my family or with a priest or chaplain, to afford me with the opportunity to receive the Roman Catholic sacraments (Anointing of the Sick, Confession and Holy Communion), and appropriate spiritual care.

6. REVOCATION

This Health Care Proxy will be revoked if:

(a) I sign a subsequent Massachusetts Health Care Proxy; or

(b) I notify my Agent or one of my Health Care Providers orally or in writing or by any other act showing a specific intent to revoke this Health Care Proxy.

7. SIGNATURE OF PRINCIPAL

I, _____, by signing this Health Care Proxy declare that I understand its contents and the
(name of principal)

effect of this grant of authority to my Agent, that I sign it willingly in the presence of each of the undersigned witnesses, and that I sign it as my voluntary act for the purposes expressed, this _____ day of _____, _____.

_____
(signature of principal)

8. WITNESSES

We, the undersigned, have witnessed the signing of this document by the principal or at the direction of the principal and state that the principal appears to be at least eighteen years of age, of sound mind and under no constraint or undue influence. We have not been named as Health Care Agent or alternate Health Care Agent in this document.

Witness One: _____

Name (print):_____

Street: _____

City/State: _____

Telephone: (_____) _____

Witness Two: _____

Name (print):_____

Street: _____

City/State: _____

Telephone: (_____) _____