

Senate Bill 542

By: Senators Hill of the 32nd, Harp of the 29th and Smith of the 52nd

AS PASSED SENATE

A BILL TO BE ENTITLED
AN ACT

1 To amend Chapter 36 of Title 31 of the Official Code of Georgia Annotated, relating to
2 durable power of attorney for health care, so as to amend the signature requirement; to
3 provide for related matters; to provide for applicability; to repeal conflicting laws; and for
4 other purposes.

5 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

6 **SECTION 1.**

7 Chapter 36 of Title 31 of the Official Code of Georgia Annotated, relating to durable power
8 of attorney for health care, is amended by striking subsection (a) of Code Section 31-36-5,
9 relating to execution of agency and limitation on agents, and inserting in lieu thereof the
10 following:

11 "(a) A health care agency shall be in writing and signed by the principal or by some other
12 person in the principal's presence and by the principal's express direction. A health care
13 agency shall be attested and subscribed in the presence of the principal by two or more
14 competent witnesses who are at least 18 years of age. ~~In addition, if at the time a health~~
15 ~~care agency is executed the principal is a patient in a hospital or skilled nursing facility, the~~
16 ~~health care agency shall also be attested and subscribed in the presence of the principal by~~
17 ~~the principal's attending physician. A durable power of attorney for health care shall have~~
18 ~~no force or effect if the declarant is a patient in a hospital or skilled nursing facility at the~~
19 ~~time the durable power of attorney for health care is executed unless the durable power of~~
20 ~~attorney for health care is signed in the presence of two witnesses as provided in this Code~~
21 ~~section at least one of whom is a member of the professional clinical staff or a social~~
22 ~~services worker designated by the chief of staff and the hospital administrator, if witnessed~~
23 ~~in a hospital, or the medical director, any physician on the medical staff who is not~~
24 ~~participating in the care of the patient, or a social services worker, if witnessed in a skilled~~
25 ~~nursing facility.~~"

1 INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER.
 2 UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE
 3 MANNER PROVIDED BELOW OR UNTIL YOU REVOKE THIS POWER OR A
 4 COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY
 5 EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR
 6 LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED, OR
 7 INCOMPETENT. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO
 8 REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW
 9 ARE EXPLAINED MORE FULLY IN CODE SECTIONS 31-36-6, 31-36-9, AND
 10 31-36-10 OF THE GEORGIA "DURABLE POWER OF ATTORNEY FOR HEALTH
 11 CARE ACT" OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS
 12 FORM). THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT
 13 FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING
 14 ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK
 15 A LAWYER TO EXPLAIN IT TO YOU.

16 DURABLE POWER OF ATTORNEY made this _____ day of _____, _____.

17 1. I, _____

18 (insert name and address of principal)

19 hereby appoint _____

20 (insert name and address of agent)

21 as my attorney in fact (my agent) to act for me and in my name in any way I could act in
 22 person to make any and all decisions for me concerning my personal care, medical
 23 treatment, hospitalization, and health care and to require, withhold, or withdraw any type
 24 of medical treatment or procedure, even though my death may ensue. My agent shall
 25 have the same access to my medical records that I have, including the right to disclose
 26 the contents to others. My agent shall also have full power to make a disposition of any
 27 part or all of my body for medical purposes, authorize an autopsy of my body, and direct
 28 the disposition of my remains.

29 THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE
 30 SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION
 31 YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH
 32 CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND
 33 OTHER LIFE-SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR
 34 AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR
 35 INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR
 36 AGENT'S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO

1 MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE OF
2 REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.

3 2. The powers granted above shall not include the following powers or shall be subject
4 to the following rules or limitations (here you may include any specific limitations you
5 deem appropriate, such as your own definition of when life-sustaining or death-delaying
6 measures should be withheld; a direction to continue nourishment and fluids or other
7 life-sustaining or death-delaying treatment in all events; or instructions to refuse any
8 specific types of treatment that are inconsistent with your religious beliefs or
9 unacceptable to you for any other reason, such as blood transfusion, electroconvulsive
10 therapy, or amputation):

11 _____
12 _____
13 _____

14 THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS
15 OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING
16 WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE
17 WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING
18 TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE
19 STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT DO NOT INITIAL
20 MORE THAN ONE:

21 I do not want my life to be prolonged nor do I want life-sustaining or death-delaying
22 treatment to be provided or continued if my agent believes the burdens of the treatment
23 outweigh the expected benefits. I want my agent to consider the relief of suffering, the
24 expense involved, and the quality as well as the possible extension of my life in making
25 decisions concerning life-sustaining or death-delaying treatment.

26 _____ Initialed _____

27 I want my life to be prolonged and I want life-sustaining or death-delaying treatment
28 to be provided or continued unless I am in a coma, including a persistent vegetative
29 state, which my attending physician believes to be irreversible, in accordance with
30 reasonable medical standards at the time of reference. If and when I have suffered such
31 an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld
32 or discontinued.

33 _____ Initialed _____

1 I want my life to be prolonged to the greatest extent possible without regard to my
2 condition, the chances I have for recovery, or the cost of the procedures.

3 Initialed _____

4 THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT
5 ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE
6 ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY
7 GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE
8 TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH
9 AND WILL CONTINUE BEYOND YOUR DEATH IF ANATOMICAL GIFT,
10 AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A
11 LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY
12 INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

13 3. () This power of attorney shall become effective on _____
14 (insert a future date or event during your lifetime, such as court determination of your
15 disability, incapacity, or incompetency, when you want this power to first take effect).

16 4. () This power of attorney shall terminate on _____
17 (insert a future date or event, such as court determination of your disability, incapacity,
18 or incompetency, when you want this power to terminate prior to your death).

19 IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND
20 ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

21 5. If any agent named by me shall die, become legally disabled, incapacitated, or
22 incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act
23 successively in the order named) as successors to such agent:

24 _____
25 _____

26 IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A
27 COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE
28 NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN
29 IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON
30 NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT
31 WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE
32 NOT REQUIRED TO, NOMINATE AS YOUR GUARDIAN THE SAME PERSON
33 NAMED IN THIS FORM AS YOUR AGENT.

6. If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:

(insert name and address of nominated guardian of the person)

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed _____

(Principal)

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

Witnesses:

Addresses:

Additional witness required when health care agency is signed in a hospital or skilled nursing facility.

I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Witness: _____

Attending Physician

Member of the professional clinic staff or social services worker designated by the chief of staff and the hospital administrator, if witnessed in a hospital, or the medical director, any physician on the medical staff who is not participating in care of the patient, or social services worker, if witnessed in a skilled nursing facility.

Address: _____

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

I certify that the signature of my agent and successor(s) is correct.

Specimen signatures of agent and successor(s)

(Agent)

(Successor agent)

(Successor agent)

(Principal)

(Principal)

(Principal)''

SECTION 3.

This Act does not in any way affect or invalidate any health care agency executed or any act of any agent prior to July 1, 2006.

SECTION 4.

All laws and parts of laws in conflict with this Act are repealed.