DURABLE POWER OF ATTORNEY FOR HEALTH CARE FOR ADULTS

This form must be filled out for everyone over the age of 17

KNOW ALL BY THESE PRESENTS

1. I, ____, the undersigned, desire of my own free will to participate in ____ sponsored by First Pentecostal Church of Pensacola Inc., wherein I shall be permitted to participate in the event above to take place ____________________, 20_______ to _________________________, 20_______, and further desire to make provision for a Durable Power of Attorney for Health Care in the event of accident, illness, or necessity of medical treatment during the course of my participation in said event.

2. I, ____, hereby make, constitute and appoint any member of the staff and/or supervisory personnel of First Pentecostal Church of Pensacola, Inc, as my attorney-in-fact to take the actions set forth in this instrument.

3. Subject to the provisions of paragraph 5 below, this instrument shall be valid and in full force and effect until ________________________________,20___ . Notwithstanding the above, this Authorization for Medical Treatment shall be valid and in full force, if due to continuing medical treatment, I am unable to return from the above-mentioned event, until such date I am able to return from the event. This instrument may be revoked by written notice delivered to the above-named agent prior thereto.

4. This instrument shall become effective only upon my subsequent incapacity, and shall commence upon certification by a physician, that I am incapacitated and am unable to make or communicate a choice regarding a particular health care decision.

5. Notwithstanding paragraph 3 above, after such certification as indicated in paragraph 4 above, this instrument shall remain in effect until I communicate a desire to revoke this instrument or take any act inconsistent with this instrument.

6. My attorney-in-fact is hereby authorized, upon my incapacity, as my true and lawful attorney, to give consent to or prohibit any type of health care, medical care, treatment, or procedure to the fullest extent legally possible, so long as the same does not contradict the most recent living will or similar directive which I shall have signed or executed before setting out on my trip listed in Paragraph 1 above.

7. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise known to my agent and shall consider my religious beliefs. In addition to and not in limitation of the language stated in this document, my agent is authorized as follows:

   (a) To arrange for transportation, whether by ambulance or otherwise, to a proper facility or emergency medical treatment or any other health care treatment would normally be administered, including, but not limited to, an emergency room hospital, a doctor's office, or a medical clinic;

   (b) To consent to and arrange for the administration of any treatment deemed necessary or advisable, including, but not limited to, any x-ray examination, anesthetic, medical or surgical diagnosis, medical or surgical treatment, and hospital care, to be rendered under the general or special supervision and on the advice of any attending physician, surgeon, or other health care provider;

   (c) To sign any releases or documents as may be required in order to obtain any medical, surgical, or other health care treatment as in required in the judgment of the medical authorities, attending physician, surgeon, or other health care provider;

   (d) To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

   (e) To authorize my admission to or the discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service

(f) To contract on my behalf any health care related service or facility on my behalf, without any agent incurring personal financial liability for such contracts;

(g) To hire and fire medical, social service, and other support personnel responsible for my care; and

(h) To take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, or other health care provider.

8. This Durable Power of Attorney for Health Care is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this Durable Power of Attorney for Health Care or separable, so that the invalidity of one or more powers shall not affect any others.

BY SIGNING HERE, I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND THE EFFECT OF THIS GRANT POWERS TO MY AGENT.

Sign ONLY in the presence of a Notary Public.

______________________________	______________________________	____________
SIGNATURE	PRINTED NAME	DATE

Notary Public

State of Florida County of ___________________

The foregoing instrument was acknowledged before me via physical presence OR online notarizations this _____________day of ___________________20_______, which is the date of the execution of this Durable Power of Attorney who is personally known OR produced identification. Type of identification produced ____________________________to be the individual described in and who executed this document, and acknowledged that he/she fully understands its contents and meaning and duly executed the same as his/her free act and deed and for the sole consideration therein stated.

Notary Public: ____

Printed Name: ____

My Commission Expires: __________________________