

A photograph of an elderly couple walking hand-in-hand on a dirt path. They are walking away from the camera towards the left. The man is wearing a dark blue polo shirt and khaki pants. The woman is wearing a light blue long-sleeved shirt, a dark vest, and dark shorts. They are walking under the shade of a large, mature tree with thick branches that arches over the path. The background shows a hazy, sunlit landscape with more trees and hills. The lighting is warm, suggesting late afternoon or early morning. Two white horizontal bars are positioned above the text.

Let's talk   
about Advance Directives

The logo consists of two horizontal orange bars of equal length, stacked vertically. A small orange triangle points upwards from the bottom center of the second bar.

Regional  
Hospice and  
Home Care  
of Western Connecticut



---

Upon admission to Regional Hospice and Home Care of Western CT, you will be asked if you have any form of an Advance Directive such as a Living Will or a Health Care Representative. If you have such a document, you will be asked to provide us with a copy so that your current wishes may be documented.

This procedure complies with state and federal law, but our primary concern is to respect and honor your personal wishes as much as possible. The care you receive will not be dependent upon your having an Advance Directive.

The information which follows is provided by the Office of the Attorney General to assist you in deciding whether and how to create an Advance Directive.

You have the right to make decisions about the medical care you receive. The interdisciplinary group of Regional Hospice and Home Care and your physician will develop a medical plan of care with you.

There may come a time when you are unable to actively participate in determining your treatment due to serious illness, injury, or other disability.

This booklet discusses the options available in Connecticut to help you convey written instructions to guide your physician, family, and Regional Hospice and Home Care regarding healthcare choices you desire to be made if you cannot express your wishes.

While we have attempted to provide accurate information, this booklet is not intended to provide any legal or medical advice, which should be obtained from your own attorney or physician.



---

## *Do I have the right to make health care decisions?*

*Yes.* Adult patients in Connecticut have the right to determine what, if any, medical treatment they will receive. If you can understand the nature and consequences of the health care decision that you are being asked to make, you may agree to treatment that may help you or you may refuse recommended treatment even if the treatment might keep you alive longer.

---

## *Do I have the right to information needed to make a health care decision?*

*Yes.* Physicians have the responsibility to provide patients with information that can help them make a decision.

*Your physician will explain:*

- What treatments may help you;
- How each treatment may affect you, that is, how it can help you and what, if any, serious problems or side effects the treatment is likely to cause;
- What may happen if you decide not to receive treatment; and
- Your physician may also recommend what, if any, treatment is medically appropriate, but the final decision is yours to make. All of this information is provided so you can exercise your right to decide your treatment wisely.

---

## *What is an Advance Directive?*

An Advance Directive is a legal document through which you may provide your directions or express your preferences concerning your medical care and/or to appoint someone to act on your behalf. Physicians and others use them when you are unable to make or communicate your decisions about your medical treatment. Advance Directives are prepared before any condition or circumstance occurs that causes you to be unable to actively make a decision about your medical care. In Connecticut, there are two types of Advance Directives:

- Living Will or health care instructions, and
- The appointment of a health care representative

---

## *Must I have an Advance Directive?*

*No.* You do not have to create a Living Will or other type of advance directive to receive medical care or to be admitted to a hospital, nursing home, hospice program, home care program or other health care facility. No person can be denied medical care or admission based on whether he or she has signed a Living Will or other type of advance directive. If someone refuses to provide you medical care or admit you unless you sign a Living Will or other type of advance directive, contact the Department of Public Health in Hartford, Connecticut at (860) 509-8000.

---

## *What is a Living Will?*

A Living Will is a document that states your wishes regarding any kind of health care you may receive. Should you be in a terminal condition or permanently unconscious, the Living Will can also tell your physician whether you want “life support systems” to keep you alive or whether you do not want to receive such treatment, even if the result is your death.

---

## *What do “terminal condition” and “permanently unconscious” mean?*

A patient is “terminal” when the physician finds that the patient has a condition which is (1) incurable or irreversible and (2) will result in death within a relatively short time if life support systems are not provided. “Permanently unconscious” means an irreversible coma or a persistent vegetative state in which the patients are not aware of their surroundings and are unresponsive.

---

## *What is a life-support system?*

A “life-support system” is an artificial means of keeping you alive and may maintain you in a state of permanent unconsciousness and prevent natural death. Life-support systems may include: devices such as ventilators (breathing machines) and dialysis; cardiopulmonary resuscitation (CPR); and/or food and fluids supplied by artificial means, such as feeding tubes and intravenous fluids. It does not include normal feeding and fluids or medications that help manage pain.



---

## *Will I receive medication for pain if I have a Living Will?*

*Yes.* A Living Will does not affect the provision of pain medication or care designed solely to maintain your physical comfort (for example, care to maintain your circulation or the health of your skin and muscles). This type of care will be provided whenever appropriate.

---

## *What is a health care representative?*

A health care representative is a person whom you authorize in writing to make any and all health care decisions on your behalf including the decision to withhold or withdraw life support systems. A health care representative does not act unless you are unable to make or communicate your decisions about your medical care. The health care representative will make decisions on your behalf based on your wishes, as stated in a Living Will or as otherwise known to your health care representative. In the event your wishes are not clear or a situation arises that you did not anticipate, your health care representative will make a decision in your best interests, based upon what is known of your wishes.

---

## *What kind of treatment decisions can be made by a health care representative?*

A health care representative can make any and all health care decisions for you, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat any physical or mental condition. The health care representative can also make the decision to provide, withhold or withdraw life support systems. The health care representative cannot make decisions for certain specific treatments which by law have special requirements.

---

## *How will my health care representative know when to get involved in making decisions for me?*

At any time after you appoint your health care representative, your health care representative can ask your attending physician to provide written notice if your physician finds that you are unable to make or communicate your decisions about your medical care. Even if your health care representative does not do so, your health care providers will usually seek out your health care representative once they determine that you are unable to make or communicate your decisions about your medical care. At this point, the health care representative becomes the sole decision maker, not the next of kin or even a conservator, unless either also serves as your health care representative.

---

## *What is a conservator?*

A “conservator of the person” is someone appointed by the Probate Court when the Court finds that a person is incapable of caring for himself/herself including the inability to make decisions about his or her medical care. A person who is conserved by a court is known as a “ward.”



The conservator of the person is responsible for making sure that the ward’s health and safety needs are taken care of and generally also has the power to give consent for the ward’s medical care, treatment and services.

You can name in advance the person you want the Court to appoint as your conservator if you become incapable of making your own decisions. If you have a conservator of the person he or she will be consulted in all medical care decisions. If you have a Living Will, however, the conservator’s consent is not required to carry out your wishes as expressed in the Living Will.

If a conservator is later appointed for you, he or she must follow your health care instructions, either as expressed in a Living Will, or as otherwise made known to your conservator while you were able to make and communicate health care decisions. Further, a conservator cannot revoke your advance directives without a Probate Court order.

---

## *How are decisions made if I have both a health care representative and a conservator?*

Generally, the decision of a health care representative will be followed if the conservator and health care representative disagree unless the probate court orders otherwise. This rule may not apply when the conservator has been appointed in some particular situations.

---

## *What Advance Directives should I have?*

If you want to be sure that your wishes about your medical care are known when you cannot express them yourself, you should have a Living Will, and you also should appoint a health care representative.

If you are unable to make or communicate your preferences for your medical care, your physician will likely look first to your Living Will as the source of your wishes. Your health care representative can make decisions on your behalf according to what is stated in your Living Will. In situations that are not addressed by your Living Will, your health care representative can make a decision in your best interests consistent with what is known of your wishes.

---

## *Who can I name as my health care representative or conservator?*

If you wish, you can name the same person to be your health care representative and to be your conservator.

The following persons cannot be named your health care representative:

- Your physician;
- If you are a patient at a hospital or nursing home or if you have applied for admission, the operators, administrators, and employees of the facility; or
- An administrator or employee of a government agency responsible for paying for your medical care.

Other than these restrictions, you can name anyone you feel is appropriate to serve as your health care representative.

**Of course, you should speak to the person whom you intend to name and be sure of his or her willingness to serve and to act on your wishes.**

---

## *Do I need a lawyer to create an Advance Directive?*

*No.* You do not need a lawyer to create an advance directive. You can use the forms in this booklet.

---

## *Do I need a notary to create an Advance Directive?*

*No.* The forms do not require the use of a notary.

---

## *Do I have to sign my Advance Directives in front of witnesses?*

*Yes.* You must sign the document in the presence of two witnesses in order for the advance directives to be valid. The witnesses then sign the form.

---

## *Who can witness my signature on an Advance Directive?*

In general, Connecticut law does not state who may or may not be a witness to your advance directive. An important exception is that the person who you appoint to be your health care representative or as your conservator cannot be a witness to your signature of the appointment form.

---

## *Once I complete an Advance Directive what should I do?*

You should tell the following persons that you have completed an Advance Directive and give them copies of the directives you made:

- Your physician;
- The person you have named as health care representative; and
- Anyone who will make the existence of your Advance Directives known if you can not do so yourself, such as family members, close friends, your clergy or lawyer.

You should also bring copies when you are admitted to a hospital, nursing home, or other health care facility. The copies will be made part of your medical record.

---

## *After I complete an Advance Directive, can I revoke it?*

*Yes.* You may revoke your Living Will or appointment of a health care representative at any time. A Living Will can be revoked either orally or in writing. If you sign a new Living Will, it will revoke any prior Living Will you made. However, to revoke your appointment of a health care representative, you must do so in writing that is observed and signed by two witnesses in order for the revocation to be valid. Remember whenever you revoke an advance directive to tell your physician and others who have copies of your advance directive.

To revoke your designation of a conservator, you can do so either in writing or by making a new designation which states that earlier designations are revoked. It is advisable to put any revocation in writing. However, once a court has appointed a conservator, it cannot be revoked without a court order.

---

## *If I already have a Living Will, do I need a new one?*

*No.* Connecticut's Living Will statutes were revised effective October 1, 2006. If your Living Will and other advance directives, such as a health care agent or power of attorney for health care, were completed prior to this date, **ACCORDING TO THE ATTORNEY GENERAL OF CONNECTICUT** they are still valid, although they are slightly different than the new advance directives. On October 1, 2006, the health care representative replaced the appointment of a health care agent and power of attorney for health care. The health care representative is, in effect, a combination of these two types of advance directives. The new Living Will makes clear that the Living Will can be used to provide your instructions regarding any type of health care, not just life support systems.



---

## *If I don't have an Advance Directive, how will my wishes be considered if I am unable to speak for myself?*

If you are unable to make and communicate your decisions concerning your medical care and you do not have a Living Will, your physician can consult with other persons to determine what your wishes are regarding the withholding or withdrawal of life support systems. If you have discussed your wishes with your physician, he or she will, of course, know your stated wishes. Your physician may also ask your health care representative, your next of kin or close relatives and your conservator, if one has been appointed, what you have told them about your wishes regarding withholding or withdrawing life-support systems. If no Living Will, such instructions are required to be specific and may need to be proven in court. You are better advised to complete a Living Will if you want to be sure that your wishes will be understood and known in the event you are unable to state them yourself.

---

## *What is a Document of Anatomical Gift?*

A Document of Anatomical Gift allows you to make a gift of all or any parts of your body to take effect upon death. Any competent adult may make an anatomical gift in writing, including through a will, a donor card, or by a statement imprinted or attached to a motor vehicle operator's license. An anatomical gift may be made for the purpose of transplants, therapy, research, medical or dental science. If you do not limit the gift's purpose to one or some of these uses, the gift can be used for any of these purposes. You may designate who receives the gift: a hospital, physician, college or organ procurement group. You may also specify that the gift be used for transplant or therapy for a particular person. If no one is named to receive the gift, any hospital may do so.

---

## *Resources include:*

New England Organ Bank  
www.NEOB.org – 800-446-6362

Donate Life New England  
www.donatelifenewengland.org  
Donate Life Connecticut  
Phone: 203-387-1549  
Email: donatelifect@gmail.com

---

## *Can I revoke an anatomical gift?*

*Yes.* An anatomical gift may be revoked or changed only by:

1. A signed statement;
2. An oral statement in the presence of two witnesses; or
3. Informing your physician if you are in a terminal condition.

An anatomical gift may not be revoked after the donor's death.

---

Regional Hospice recognizes that the task of formulating an Advance Directive in a timely and objective manner can be difficult for many people. The confusion caused by the sudden onset of disease or even the consideration of questions of aging and mortality can be very disquieting.

Most people find themselves in need of at least some assistance. Perhaps you would like terminology clarified, options explained, and questions answered regarding a variety of treatment options. While having an Advance Directive can relieve anxiety in your own life and be welcomed as a gift by your family, the process can be daunting.

If you would prefer to speak with someone before completing your Advance Directive, please feel free to contact:

**Regional Hospice and Home Care of Western Connecticut, Inc.**  
**203.702.7400**

**[www.regionalhospicect.org](http://www.regionalhospicect.org)**





Name: \_\_\_\_\_

## What My Requests Are:

(Please check the ones that apply)

### Comfort

- I do not want to be in pain. I want enough medicine to relieve my pain, even if that means I will be drowsy or sleepy.
- If I have depression, nausea, shortness of breath, or hallucinations, I want my caregivers to do whatever possible to help me.
- I would like a cool, moist cloth on my forehead if I have a fever.
- I want my lips and mouth moistened if dry.
- I wish to continue baths to keep fresh and clean at all times for as long as possible.
- I wish to be massaged as often as possible.
- I would like my favorite music playing until the time of my death.
- I wish to have personal care such as teeth brushing, shaving and nail care, as long as it does not cause discomfort or pain.
- I wish to be read to from selections I choose when I am near death.
- I wish to know about my options for hospice care for me and my loved ones.

### How I would like to be treated

- I would like people with me at all times, especially when it seems that death is near.
- I would like to have my hand held and to be talked to even if I'm unresponsive.
- I would like others by my side praying for me when possible.
- I would like the members of my faith community to know that I am sick and to pray for me and visit.
- I would like my caregivers to be kind and cheerful, and not sad.
- I would like pictures of those I love near my bed.
- If I am incontinent, I would like to be kept as clean as possible with frequent bed linen and clothing changes.
- I would like to die at home, if at all possible.

### What my loved ones should know

- I would like my family and friends to know that I love them.
- I would like my family, friends and others to forgive me for hurting them as I have forgiven them for when they may have hurt me.
- I want my family and friends to know that I do not fear death. It is not the end but a new beginning for me.
- I would like for my family members to make peace with each other before my death, if possible.
- I would like my family and friends to remember me as I was before I became seriously ill.
- I would like for my family and friends to respect my wishes even if they disagree with them.
- I would like my family and friends to experience my illness as a time for personal growth for every one, myself included. I would like my final days to have meaning.
- I would like for my family and friends to reach out for help if they have trouble with my death. I want memories of my life to bring them happiness, not sorrow.

After my death, I would like my body to be:  buried or  cremated

*Continued on back...*

I would like my remains in the following location(s):

---

---

---

---

The following people know my funeral wishes:

---

---

---

---

I would like to be remembered in the following ways:

---

---

---

---

I would like my memorial service to include the following (music, songs, readings, etc.):

---

---

---

---

Other requests:

---

---

---

---

# Appointment of Health Care Representative

I understand that, as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and will turn to someone who knows my values and health care wishes. By signing this appointment of health care representative, I appoint a health care representative with legal authority to make health care decisions on my behalf in such case or at such time.

I appoint \_\_\_\_\_  
to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment **my health care representative is authorized to make any and all health care decisions for me, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and the decision to provide, withhold or withdraw life support systems,** except as otherwise provided by law which excludes for example psychosurgery or shock therapy.

I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in a Living Will, or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If \_\_\_\_\_ is unwilling or unable to serve as my health care representative,

I appoint \_\_\_\_\_ to be my alternative health care representative.

This request is made, after careful reflection, while I am of sound mind.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signature

## Witnesses' Statements

This document was signed in our presence by \_\_\_\_\_  
the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

_____ Witness	_____ Witness
_____ Number and Street	_____ Number and Street
_____ City, State and Zip Code	_____ City, State and Zip Code



OPTIONAL FORM

### Witnesses' Affidavits

STATE OF CONNECTICUT )  
 )  
 ) :SS. \_\_\_\_\_  
 ) (Town)  
 COUNTY OF \_\_\_\_\_ )

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this appointment of a health care representative by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

_____ Witness	_____ Witness
_____ Number and Street	_____ Number and Street
_____ City, State and Zip Code	_____ City, State and Zip Code

Subscribed and sworn to before me by \_\_\_\_\_  
 and \_\_\_\_\_, the signing witnesses to the foregoing affidavit  
 this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
 Commissioner of the Superior Court  
 Notary Public  
 My Commission expires: \_\_\_\_\_

*(Print or type name of all persons signing under all signatures)*



# Living Will or Health Care Instructions

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, \_\_\_\_\_, **the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.**

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

## *Specific Instructions*

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment.

	<u>Provide</u>	<u>Withhold</u>
Cardiopulmonary Resuscitation	_____	_____
Artificial Respiration (including a respirator)	_____	_____
Artificial means of providing nutrition and hydration	_____	_____
_____	_____	_____
_____	_____	_____

Other specific requests:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.**

This request is made, after careful reflection, while I am of sound mind.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature



# Witnesses' Statements

This document was signed in our presence by \_\_\_\_\_  
the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Number and Street

\_\_\_\_\_  
Number and Street

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
City, State and Zip Code



OPTIONAL FORM

### Witnesses' Affidavits

STATE OF CONNECTICUT )  
 )  
 ) :SS. \_\_\_\_\_  
 ) (Town)  
 COUNTY OF \_\_\_\_\_ )

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this living will or health care instructor by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
 Witness  
 \_\_\_\_\_  
 Number and Street  
 \_\_\_\_\_  
 City, State and Zip Code

\_\_\_\_\_  
 Witness  
 \_\_\_\_\_  
 Number and Street  
 \_\_\_\_\_  
 City, State and Zip Code

Subscribed and sworn to before me by \_\_\_\_\_  
 and \_\_\_\_\_, the signing witnesses to the foregoing affidavit  
 this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
 Commissioner of the Superior Court  
 Notary Public  
 My Commission expires: \_\_\_\_\_

*(Print or type name of all persons signing under all signatures)*



# Statutory Short Form Power of Attorney

NOTICE: The powers granted by this document are broad and sweeping. They are defined in Connecticut Statutory Short Form Power of Attorney Act, sections 1-42 through 1-56, inclusive, of the general statutes, as amended by 2006 Public Act 06-195, which expressly permits the use of any other or different form of power of attorney desired by the parties concerned. The grantor of any power of attorney or the attorney-in-fact may make application to a court of probate for an accounting as provided in subsection (b) of Connecticut laws on accounting.

Know all Men by these Presents, which are intended to constitute a GENERAL POWER OF ATTORNEY pursuant to Connecticut Statutory Short Form Power of Attorney Act:

That I, \_\_\_\_\_, of \_\_\_\_\_, Connecticut,  
(Print your name) (Town)

do hereby appoint:

[WRITE IN NAME, TOWN, AND STATE OF ONE OR MORE INDIVIDUALS OR CORPORATIONS TO ACT AS YOUR ATTORNEY-IN-FACT; ADD MORE IF NECESSARY; "x" OUT LINES NOT COMPLETED]

\_\_\_\_\_, of \_\_\_\_\_,  
Name Town and State

\_\_\_\_\_, of \_\_\_\_\_,  
Name Town and State

\_\_\_\_\_, of \_\_\_\_\_,  
Name Town and State

as my attorney(s)-in-fact TO ACT:

CHECK ONE BOX IF APPOINTING MORE THAN ONE ATTORNEY-IN-FACT

- SEVERALLY (independently)
- JOINTLY (requiring both to consent and sign)

First: in my name, place and stead in any way which I myself could do, if I were personally present, with respect to the following matters as each of them is defined in the Connecticut Statutory Short Form Power of Attorney Act to the extent that I am permitted by law to act through an agent:

(Strike out and initial in the opposite box any one or more of the subdivisions as to which the principal does NOT desire to give the agent authority. Such elimination of any one or more of subdivisions (A) to (L), inclusive, shall automatically constitute an elimination of subdivision (L).)

NOTE: To strike out any subdivisions the principal must draw a line through the text of that subdivision AND write his or her initials in the box opposite. [If you do not draw a line through and initial, you are giving your agent authority to exercise all of the following powers.

*Continued on back...*

# Statutory Short Form Power of Attorney (Continued)

- |   |                          |   |                          |
|---|--------------------------|---|--------------------------|
| (A) Real estate transactions                | <input type="checkbox"/> | (G) Estate transactions;                | <input type="checkbox"/> |
| (B) Chattel and goods transactions;         | <input type="checkbox"/> | (H) Claims and litigation;              | <input type="checkbox"/> |
| (C) Bond, share and commodity transactions; | <input type="checkbox"/> | (I) Personal relationships and affairs; | <input type="checkbox"/> |
| (D) Banking transactions                    | <input type="checkbox"/> | (J) Benefits from military service;     | <input type="checkbox"/> |
| (E) Business operating transactions;        | <input type="checkbox"/> | (K) Records, reports and statements;    | <input type="checkbox"/> |
| (F) Insurance transactions;                 | <input type="checkbox"/> | (L) All other matters;                  | <input type="checkbox"/> |

[NOTE: You may insert additional powers here]

---

---

---

Second: with full and unqualified authority to delegate any or all the foregoing powers to any person or persons whom my attorneys-in-fact shall select.

Third: hereby ratifying and confirming all that said attorneys or substitutes do or cause to be done.

In Witness Whereof, I have hereunto signed my name and affixed my seal this

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.  
(date) (month) (year)

(L.S.) \_\_\_\_\_  
Signature

WITNESSES (one of whom may be the notary, attorney, etc. taking the acknowledgment)  
Attested and subscribed in the presence of the principal and subsequent to the principal subscribing same:

First Witness signs: \_\_\_\_\_ Second Witness signs: \_\_\_\_\_

Print Witness name: \_\_\_\_\_ Print Witness name: \_\_\_\_\_

STATE OF CONNECTICUT )  
) ss: at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_  
COUNTY OF \_\_\_\_\_ (Town) (month) (day) (year)

Personally Appeared \_\_\_\_\_, Signer and Sealer of the foregoing instrument,  
and acknowledged the same to be his/her free act and deed, before me.

\_\_\_\_\_  
Commissioner of the Superior Court  
or  
Notary Public  
(if notary) My commission expires: \_\_\_\_\_





**Regional  
Hospice and  
Home Care**  
of Western Connecticut

405 Main Street  
Danbury  
Connecticut  
06810

PHONE  
203.702.7400

FAX  
203.702.7401

EMAIL  
[Info@regionalhospicect.org](mailto:Info@regionalhospicect.org)

[www.regionalhospicect.org](http://www.regionalhospicect.org)

