

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

I, Fulton J. Sheen  
(print full name)

was born April 14, 1957, and I live at  
(give date)  
1928 Sheen Hollow Otsego, MI 49078  
(full address)

I am an adult, I am of sound mind, and I am voluntarily choosing to appoint

Cheryl Sheen  
(name patient advocate)

living at 1928 Sheen Hollow Otsego MI 49078,  
(address)  
to be my patient advocate.

If this person cannot or will not serve as my patient advocate, I designate

Jessica Strickler  
(name of 2nd choice)

living at 5809 Hidden Oak Ave. Richland, MI 49083  
(address)  
to be my patient advocate instead.

I authorize and direct my patient advocate to make decisions for me regarding my care, custody, and medical treatment if I become unable to participate in medical treatment decisions for myself.

In making decisions for me, my patient advocate shall follow my wishes to the best of his or her knowledge and ability. This includes wishes I have expressed in writing and which I have not later rejected.

I give my patient advocate the following responsibilities:

- access to my medical records;
- authority to arrange medical services for me, including admission to a hospital, nursing home, or other care facility, and to pay for these services with my money;
- authority to consent to medical treatment for me, including the use of prescription medication, or to refuse treatment on my behalf.
- power to hire and fire medical personnel, including my attending physician.

PA means my Patient Advocate will decide

NO means No

## PROTECTIVE MEDICAL DECISIONS DECLARATION

The following values history serves as a set of specific values-based directives for various medical interventions. It is to be used only in health care situations where I am unable to participate in making my own medical decisions and where my preferences concerning medical care are relevant. I direct that this values history and Protective Medical Decisions Declaration be made part of my medical record. A check and my initials beside each value indicates my beliefs and desires:

PA X

1. Although I do not wish to suffer great pain, I do not authorize anyone to carry out any action with the purpose of ending my life.

PA X

2. Since food and water are basic substances for physical existence, I authorize their withdrawal only when the following criteria have been met:

PA

a. When, in the best medical judgment, my death will occur within a reasonable matter of hours or days, to be determined by my patient advocate;

NO

b. When the intent is not to hasten my death but to provide additional relief from pain and suffering;

PA X

c. When my appointed advocate(s) have given written consent;

NO

d. When it has been indicated on my medical record that the withdrawal of food and water does not mean the withdrawal of pain medication or other means of comfort care;

NO

e. When my physical condition has deteriorated to the point where I am no longer able to assimilate hydration and nutrition.

PA

3. I authorize the administration of pain medication with the understanding that in attempting to control pain my life may be shortened by the use of narcotics.

PA

4. Under the conditions listed below, I wish to undergo cardiopulmonary resuscitation:

PA

a. Once.

PA

b. Twice.

PA X

c. As many times as necessary to restore heart and lung functions.

NO

d. Never.

NO

e. Other (explain).

PA X

5. Under the conditions listed below I want to be placed on a ventilator:

NO

a. In all circumstances.

NO

b. For a trial period to determine effectiveness using reasonable medical judgment.

PA X

c. Under no circumstances.



NO 6. I want to have all medications used for the treatment of my illness continued provided such medication continues to be physically beneficial.

NO 7. I authorize the use of nasogastric (nasal) \_\_\_\_, gastric (stomach) \_\_\_\_, or other enteral feeding tubes \_\_\_\_, to facilitate my medical and/or comfort care.

NO 8. I authorize being placed on a dialysis machine under the following conditions:

NO a. Under all circumstances where such treatment would be beneficial to my physical condition.

NO b. For a trial period of \_\_\_\_\_ to determine effectiveness using reasonable medical judgment.

FD X c. Under no circumstances.

FD X 9. I wish to authorize the use of surgery.

PA 10. I wish to authorize the use of a blood transfusion.

PA 11. PA I wish to authorize an autopsy to determine the cause of my death.

PA I do **not** wish to authorize an autopsy to determine the cause of my death.

PA 12. I want to be admitted to the Intensive Care Unit under the following conditions:

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NO 13. If I am residing in a long-term care facility and experience a life-threatening change in my health status, I want 911 or other emergency personnel called in case of a medical emergency.

FD X 14. If I have been diagnosed as being terminally ill (death will most likely occur within one year) I do not wish to be resuscitated by emergency personnel (911 or other emergency personnel).

Q 15. If I am pregnant at such time as I am unable to make my own medical decisions, all efforts must be undertaken to maximize survival for me and my unborn child.

PA 16. PA I wish to donate my major organs.

PA I do **not** wish to donate my major organs.

FD X 17. Upon my death, I want my body to be treated with respect.

**SPECIAL PARAGRAPH: (optional)**

By my signature below, I want to make it clear that my patient advocate is authorized to make a decision to withhold or withdraw treatment even when such decisions allow me to die.

*Fulton J. Sheen*

(Sign here if you wish to give your patient advocate this authority.)

Optional:

My specific wishes regarding treatment are:

Under no circumstances do I authorize being admitted to a hospital or any other medical facility in the event of a health emergency or illness. I do not want ANY medical professionals or government authorities to make ANY decisions on my care, except my chosen medical durable power attorneys on this form. I authorize legal action be taken against any medical professional, government official who does not follow my instructions. I do not authorize ANY Covid tests or vaccinations.

I want my family, and my patient advocate to be protected by this document from any civil or criminal penalties for honoring my wishes as I have expressed them here, or as implemented by my patient advocate.

I retain the right to revoke this document at any time, and by any means.

Photocopies of this document, after it is signed by me and my witnesses, shall/shall not have the same legal force as the original.

(cross out one)(circle one)

11/16/21

(date)

*Fulton J. Sheen*

(signature)

**WITNESSES' STATEMENT**  
**Durable Power of Attorney for Health Care**

This document was signed by Fulton Sheen  
(name)  
in my presence. I believe that he/she is of sound mind, and has signed it voluntarily, without duress, fraud, or undue influence.

I further state that I am an adult, and that I will not receive any assets when he/she dies. I am not his/her spouse, parent, child, grandchild, sibling, physician, or patient advocate. Furthermore, I am not an employee of a life or health insurance provider for him/her, an employee of a health facility that is treating him or her, or an employee of a home for the aged where he/she resides.

signed by 1st witness:

Bruce Leonardson

(signature)

BRUCE LEONARDSON

(print full name)

address:

7534 Farmington

KACAMAZOO, MI 49009

signed by 2nd witness:

Michele Pulver

(signature)

Michele Pulver

(print full name)

address:

204 E Orleans St

Oshtemo, MI 49078



## Acceptance of Durable Power

I, Cheryl Sheen,  
am over 18 years old. I have read the Durable Power of Attorney for Health Care signed by  
Fulton J. Sheen on 11/16/21.

I accept the responsibility to protect his/her wishes as expressed in that document when and if he/she becomes unable to participate in medical treatment decisions. I recognize the following legal requirements:

1. This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.
2. I 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.
3. 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 pregnant patient's death.
4. I 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 I am authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient to die.
5. I shall not receive compensation for the performance of my authority, rights and responsibilities, but I may be reimbursed for actual and necessary expenses incurred in the performance of my authority, rights and responsibilities.
6. I 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.
7. A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
8. I may revoke this acceptance at any time and in any manner sufficient to communicate an intent to revoke.
9. 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 1978, being Section 333.20201 of the Michigan Compiled Laws.

I recognize that if Fulton J. Sheen  
receives care in a hospital, or any other medical care facility, he/she will have certain rights  
which I must try to protect. These include:

1. Confidentiality of medical records.
2. The right to inspect medical records, or have me inspect them on his/her behalf if this Durable Power becomes effective.
3. The right to information regarding his/her medical condition, proposed treatment and prospects for recovery, and to have me receive that information after this Durable Power becomes effective.
4. Adequate and appropriate care.
5. The right to refuse treatment as provided by law.
6. Right to receive information regarding the facility's procedures for responding to patient complaints, and to have me receive that information or employ those procedures on his/her behalf if this Durable Power becomes effective.
7. Right to be free from physical and mental restraint, except as necessary to prevent injury.

11/16/21  
(Date)

Cheryl Sheen  
(Signature)

Cheryl Sheen  
(Printed Name)

1928 Sheen Holw

Otsego, MI 49078  
(Full address)



"Stand-by"  
Acceptance of Durable Power  
by Secondary Patient Advocate

I, Jessica Strickler

am over 18 years old. I have read the Durable Power of Attorney for Health Care signed by

Fulton J. Sheen

on 12/7/21

If the primary patient advocate cannot serve, or revokes his/her acceptance, then I accept the responsibility to protect Fulton Sheen's wishes as expressed in the DPOA when and if he/she becomes unable to participate in medical treatment decisions. I recognize the following legal requirements:

1. This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.
2. I 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.
3. 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 pregnant patient's death.
4. I 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 I am authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient to die.
5. I shall not receive compensation for the performance of my authority, rights and responsibilities, but I may be reimbursed for actual and necessary expenses incurred in the performance of my authority, rights and responsibilities.
6. I 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.
7. A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
8. I may revoke this acceptance at any time and in any manner sufficient to communicate an intent to revoke.
9. 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 1978, being Section 333.20201 of the Michigan Compiled Laws.



I recognize that if Fulton Sheen receives care in a hospital, or any other medical care facility, he/she will have certain rights which I must try to protect. These include:

1. Confidentiality of medical records.
2. The right to inspect medical records, or have me inspect them on his/her behalf if this Durable Power becomes effective.
3. The right to information regarding his/her medical condition, proposed treatment and prospects for recovery, and to have me receive that information after this Durable Power becomes effective.
4. Adequate and appropriate care.
5. The right to refuse treatment as provided by law.
6. Right to receive information regarding the facility's procedures for responding to patient complaints, and to have me receive that information or employ those procedures on his/her behalf if this Durable Power becomes effective.
7. Right to be free from physical and mental restraint, except as necessary to prevent injury.

12/7/21

(Date)

Jessica Stricker

(Signature)

Jessica Stricker

(Printed Name)

5809 Hidden Oak Ave  
Richland, MI 49083

(Full address)