SOUTH DAKOTA
POWER OF ATTORNEY FOR HEALTH CARE

PROVIDED BY
CAKE (JOINCAKE.COM)

Durable Power of Attorney *for Health Care*

Fill out this document carefully. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will be in effect unless or until you revoke it. You may change or revoke this document at any time by telling your doctor and other healthcare providers. You should give copies of this document to your family, your doctor and your health care facility. This form is optional. If you choose to use this form, the form has a signature line for you and a notary.

I,_____, _____appoint _____
(Principal/Patient) *(Birthday)* *(Decision Maker/Agent)*

as my Attorney-In-Fact for the purpose of making healthcare decisions on my behalf. In the event the person named above is unable or unwilling to act as my Attorney-In-Fact, I appoint

(Optional) _____as my Attorney-In-Fact. In the event both of the previously named persons are either unable or unwilling to act as my Attorney In Fact, I appoint

(Optional) _____ as my Attorney-In-Fact. This Power of Attorney shall become effective upon my disability as authorized by SD Codified Law §§ 59-7-2.1-2.8.

I grant my Attorney-In-Fact the power to:

(Initial) _____Make any and all health care decisions on my behalf, including each of the powers identified in items 1-7 below:

OR

I only grant my Attorney-In-Fact the power to (initial each power granted):

1) _____ Consent to healthcare on my behalf.
2) _____ Withdraw consent for healthcare.
3) _____ Reject care or treatment recommended by a healthcare provider in accordance with my previously stated wishes.
4) _____ Authorize a healthcare provider to withhold care or treatment when such care or treatment would prolong my suffering.
5) _____ Authorize artificial nutrition to be withheld or withdrawn.
6) _____ Authorize artificial hydration to be withheld or withdrawn.
7) _____ Other /Additional Instructions (specify): _____
_____

Dated this, the_____day of _____, 20 _____. _____
(Principal/Patient)

State of South Dakota)
) ss
County of Pennington)

On this _____ day _____ ,20 _____ , _____, known to me or satisfactorily proven to be the person named above, personally appeared before me, a Notary Public with the State of South Dakota, and acknowledged that he or she executed the same for the purposes stated herein.

Notary Public_____ Seal
My commission expires_____

Produced by
Regional Health
Learning & Development Department
353 Fairmont Boulevard, Rapid City, SD 57701

CRITICAL STEP:
SHARE YOUR COMPLETED DOCUMENT!

Your document is only helpful if people know where to find it when it is needed. It's important to discuss the decisions outlined in your document with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your document once it has been completed and satisfies the legal requirements for your state (if applicable).

WHO NEEDS A COPY OF YOUR DOCUMENT?

- Anyone assigned a decision-making role in the document
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

HOW TO SHARE YOUR DOCUMENT

1) **Use Cake!** Upload your document to a free Cake account for safekeeping. Share 24/7 secure document access with anyone that has an email address*

   Create your free Cake account: www.joincake.com/share-free

2) **Or, print** and provide copies to everyone who needs one

WHY PLAN & SHARE WITH CAKE?

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print all your end-of-life documents
- Share 24/7 document access with anyone that has an email address*

Create your free Cake account: www.joincake.com/share-free

** Some healthcare providers may require a paper copy of your document to be able to enter it into their records.*