MICHIGAN PATIENT ADVOCATE DESIGNATION – PAGE 1 OF 6

PRINT YOUR NAME AND ADDRESS

I Lawrence P. Tessari
(name)

5871 Pine St. Taylor, MI 48180
(address)

am of sound mind, and I voluntarily make this designation.

PRINT THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR PATIENT ADVOCATE

I designate Annette M. Tessari
(name of primary patient advocate)

residing at 5871 Pine St. Taylor, MI 48180
(address)

(313) 510- 6566
(home phone number) (work phone number)

as my patient advocate to make care, custody, medical, or mental health treatment decisions for me in the event that I become unable to participate in medical treatment decisions. The determination of when I am unable to participate in medical and/or mental health treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

If my first choice is unable, unwilling, or not reasonably available to serve as my patient advocate, then I designate:

PRINT THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR ALTERNATE PATIENT ADVOCATE

Natalie M, Tessari
(name of alternate patient advocate)

residing at 8855 Ball St. Plymouth, MI. 48170
(address)

(734) 680-2789
(home phone number) (work phone number)

to serve as my patient advocate.

YOU MAY CROSS OUT AND INITIAL ANY PARTS OF THIS FORM THAT YOU DO NOT AGREE WITH

I authorize my patient advocate to decide to withhold or withdraw medical and mental health treatment, including the provision of artificial nutrition and hydration, which could or would allow me to die. I am fully aware that such a decision could or would lead to my death.

In making decisions for me, my patient advocate shall be guided by my wishes, whether expressed orally, in this designation, or in another document. If my wishes as to a particular situation have not been expressed, my patient advocate shall be guided by his or her best judgment of my probable decision, given the benefits, burdens and consequences of the decision, even if my death, or the chance of my death, is one consequence.

My patient advocate shall have the same authority to make care, custody, and medical and mental health treatment decisions as I would if I had the capacity to make them, including admission to a hospital or nursing care facility and paying for such services with my funds, EXCEPT (here list the limitations, if any, you wish to place on your patient advocate's authority):

LIST INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR PATIENT ADVOCATE'S AUTHORITY

I specifically prohibit any court, or any other governmental entity from appointing for me, any professional guardian, at any time, for any reason, in perpetuity. I shall not be admitted to any CATHOLIC hospitals, group homes, hospice, palliative care, "Death with Dignity", or other medical groups that attempt to end my live. None of my organs shall be donated. I shall not be given psychotropic drugs, morphine, or fentanyl. I shall be buried in a cemetery that is not in a congested city location. Recommended is United Memorial Gardens in Plymouth. A burial site next to mine shall be purchased for my wife.

(Attach additional pages, if needed)

This designation of patient advocate shall not be affected by my disability or incapacity. This designation of patient advocate is governed by Michigan law, although I request that it be honored in any state in which I may be found. I reserve the power to revoke this designation at any time by communicating my intent to revoke it in any manner in which I am able to communicate.

Photocopies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

CROSS OUT AND INITIAL THIS STATEMENT IF YOU DO NOT AUTHORIZE YOUR PATIENT ADVOCATE TO MAKE AN ANATOMICAL GIFT

In the hope that I may help others, I authorize my patient advocate to make this anatomical gift if medically acceptable, to take effect upon my death and to resolve any conflict between the terms of this Designation and the administration of means necessary to ensure the medical suitability of my anatomical gift. The words and marks below indicate my desires.

INITIAL YOUR CHOICES

REGARDING ORGAN DONATION

Upon my death, I wish to donate:

_____ My body for anatomical study if needed.

_____ Any needed organs, tissues, or eyes.

_____ Only the following organs, tissues, or eyes:
None L.T.

LIST LIMITATIONS OR SPECIAL WISHES, IF ANY

I authorize the use of my organs, tissues, or eyes:

_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

This authority granted to my patient advocate to make an anatomical gift is limited as follows (list any limitations or special wishes here, if any):

_____

_____

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

I further direct that:

_____

_____

_____

_____

_____

_____

_____

_____

ATTACH ADDITIONAL PAGES IF NEEDED

(Attach additional pages, if needed)

MICHIGAN PATIENT ADVOCATE DESIGNATION - PAGE 4 OF 6

SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR ADDRESS

I voluntarily sign this designation of patient advocate after careful consideration. I accept its meaning and I accept its consequences.

Your signature: Laura Lam

Date: 7/9/2020

5871 Pine St

(your street address)

Taylor, MI 48180

(city, Michigan, zip code)

Statement of Witnesses

We sign below as witnesses. This designation was signed in our presence. The designator appears to be of sound mind, and to be making this designation voluntarily, and under no duress, fraud, or undue influence.

YOUR WITNESSES MUST SIGN AND DATE HERE AND PRINT THEIR NAMES AND ADDRESSES

Witness 1: Edith M Tarr

(signature)

Date: 7-16-20

Edith M Tarr

(print or type full name)

16261 Harden Circle Southfield mi 48076

(address)

Witness 2: Shaneka Dorsey

(signature)

Date: 7-16-20

Shaneka Dorsey

(print or type full name)

2933 Evergreen Southfield MI 48076

(address)

NOTE: YOUR PATIENT ADVOCATE MUST SIGN AN ACCEPTANCE FORM BEFORE HAVING AUTHORITY TO MAKE DECISIONS ON YOUR BEHALF

THIS ACCEPTANCE MAY BE OBTAINED NOW TO STREAMLINE THE PROCESS

Acceptance by Patient Advocate and Alternate Patient Advocate (If Any)

1. This patient advocate designation is not effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in section 5506, the authority remains exercisable after the patient's death.

2. A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health 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 patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant if that would result in the pregnant patient's death.

4. A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

5. A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

6. A patient advocate 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 or mental health treatment decisions are presumed to be in the patient's best interests.

7. A patient may revoke his or her patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

8. A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

9. A patient advocate may revoke his or her acceptance of the patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

10. A patient admitted to a health facility or agency has the rights enumerated in section 20201 of the public health code, 1978 PA 368, MCL 333.20201.

I understand the above conditions, terms and responsibilities and I accept the designation as patient advocate for

YOUR PATIENT ADVOCATE MUST SIGN AND DATE YOUR DOCUMENT HERE BEFORE MAKING DECISIONS ON YOUR BEHALF

Annette M, Tessari

(name of primary patient advocate)

Dated July 15, 2020 Signed Annette Tessari

I understand the above conditions and I accept the designation of successor patient advocate for

YOUR ALTERNATE PATIENT ADVOCATE MUST SIGN AND DATE YOUR DOCUMENT HERE BEFORE MAKING DECISIONS ON YOUR BEHALF

Natalie C. Tessari

(name of alternate patient advocate)

Dated 8/6/2020 Signed Natalie Tessari

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

MICHIGAN ORGAN DONATION FORM - PAGE 1 OF 1

ORGAN DONATION (OPTIONAL)

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Michigan law.

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

L.T. I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

ADD NAME OR INSTITUTION (IF ANY)

_____ Pursuant to Michigan law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

Declarant name: Lawrence P Tessari

Declarant signature: Lawrence P Tessari, Date: 7-9-2020

The declarant voluntarily signed or directed another person to sign this writing in my presence.

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness Edith M. Tessari Date 7-16-20

Address 16261 Braden Circle
Southfield MI 48075

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness Shonta Dorsey Date 7-16-20

Address 2930 Evergreen
Southfield MI 48076