Request #1

Stay Home!!!

Request #2 -PPE

Personal Protective Equipment

Request for Donations:

* N95 Masks
* Dust/Painting Masks
* Nitrile gloves

New and sealed only

Request #2 - PPE

Drop off location for PPE

New/sealed materials only

Office of Emergency Management

3755 Mark Dabling Blvd.

Colorado Springs, CO

Tuesday & Thursday 1pm - 4pm

Request #2 - PPE

Requests from Businesses and Institutions:

- ✓ N95 Masks
- ✓ Dust/Painting Masks
- ✓ Nitrile Gloves
- ✓ Protective head coverings
- ✓ Gowns
- ✓ Eye Protection/ Goggles
- ✓ Hand Sanitizer
- ✓ Disinfectant wipes

Company Outreach

Bart Evans

Emergency Preparedness Planner

Pikes Peak Regional Office of Emergency Management

719-575-8418

bartevans@elpasoco.com

Request #3

Medical Decision Making Paperwork

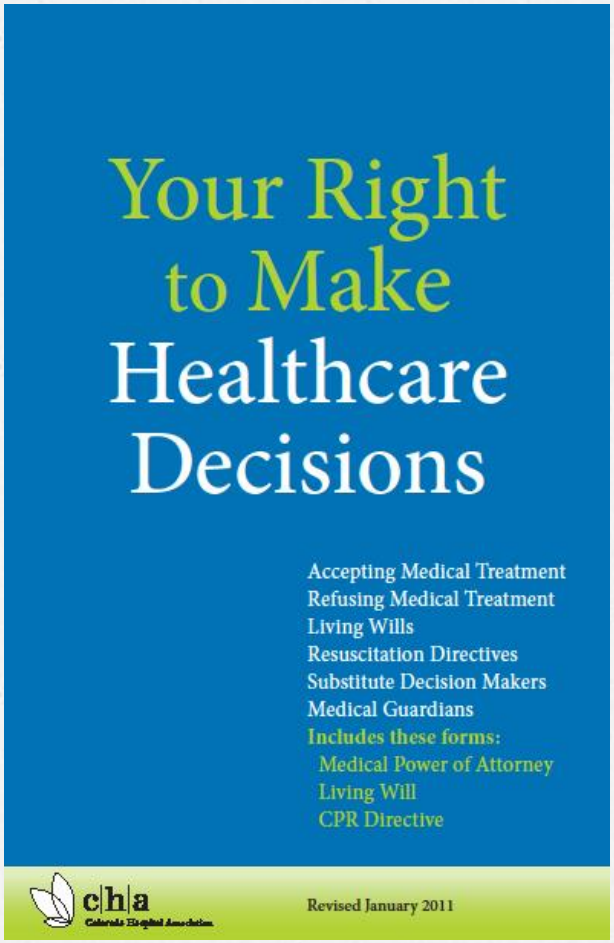
http://www.coloradoadvancedirectives.com/

About CADC

The ***Colorado Advance Directives Consortium*** (CADC) is an informal organization of professionals in healthcare, senior services, law, and ethics dedicated to improving the tools and processes for healthcare decision making in Colorado.

Request #3

www.ColoradoAdvanceDirectives.com



Single copies of this booklet are available at no cost from the Colorado Hospital Association, 720-489-1630

Request #3

Medical Durable Power of Attorney for Healthcare Decisions

I. Appointment of Agent and Alternates

I, _____,
Declarant, hereby appoint:

_____
Name of Agent

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

_____
Name of Alternate Agent #1

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

_____
Name of Alternate Agent #2

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

II. When Agent's Powers Begin

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either (initial one):

_____ (*Initials*) Immediately upon my signature.

_____ (*Initials*) When my physician or other qualified medical professional has determined that I am unable to make my or express my own decisions, and for as long as I am unable to make or express my own decisions.

III. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

My signature below indicates that I understand the purpose and effect of this document:

_____
Signature of Declarant *Date*

Pursuant to Colorado Revised Statute 15–14.503–509

Request #3

Addendum to Medical Durable Power of Attorney — *recommended, not required*

1. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (name of Declarant)

_____ .

I am at least eighteen (18) years old. I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

_____
Primary Agent's Signature

_____
Printed Name

_____
Date

_____
Alternate Agent #1 Signature

_____
Printed Name

_____
Date

_____
Alternate Agent #2 Signature

_____
Printed Name

_____
Date

2. Signature of Witnesses and Notary

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by (*name of Declarant*)

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We are at least eighteen (18) years old.

_____
Signature of Witness

_____
Printed Name

_____
Address

_____

_____
Signature of Witness

_____
Printed Name

_____
Address

_____

Notary (optional)

State of _____
County of _____
SUBSCRIBED and sworn to before me by
_____, the Declarant,
and _____
and _____
witnesses, as the voluntary act and deed of the Declarant this
day of _____, 20____.

_____
Notary Public
My commission expires: _____

Pursuant to Colorado Revised Statute 15–14.503–509

Request #4

Support your Healthcare Workers and First Responders

“The overriding request”

Stay Home!!!