HEALTH CARE PROXY

To: My Family, my Physicians, my Lawyer, any Medical Facility in whose care I happen to be, any Individual who may become responsible for my Health Affairs, and All Others Whom It May Concern:

1. Print Name: _____ Birth Date: _____

Address: _____ Social Security #: _____

This form is for appointing another person as your agent to make decisions about your medical treatment if for some reason you lose the capacity to make a medical decision. It is **very important** that you discuss your wishes with your agent and your doctor. In particular, **you must tell** your agent what your wishes would be on artificial nutrition and hydration or else your agent cannot decide on your behalf. You are also encouraged to complete an Advance Care Directive **(Living Will).**

I, _____ , hereby name the following person(s) as my Health Care Agent(s).

Name: _____

Address: _____

All Phone Numbers: _____

2. Alternate Health Care Agent is (optional, to serve if agent is unavailable)

Name: _____

Address: _____

All Phone Numbers: _____

My health care agent may make any and all health care decisions for me, except to the extent that I state otherwise. This agent shall take effect should I become unable to make my own health care decisions.

3. Instructions: I direct my agent to make health care decisions **according to my wishes and instructions which I have shared with my agent.** I have the following limitations or special instructions (for additional space use the last page of this form). Examples are given in the booklet you received with this document. Discuss your thoughts, feelings and questions about this document with your doctor.

4. Unless I change this, the proxy shall remain in effect indefinitely, or until the date or conditions stated below.

This proxy shall expire (specific date or conditions, if desired) _____

_____

_____

5. *Your signature (this must be signed in the presence of two (2) adults that are **NOT** persons you named as your proxy or alternate proxy).*

Signed: _____ Today's Date: _____

(Sign and Date this document)

6. Witness *(must be two (2) adults).* **I declare that the person who signed this document is known to me and is acting of his/her own free will. He/she signed (or asked another to sign for him/her) this document in my presence.**

Witness #1

Your signature: _____ Print Name: _____ Today's Date: _____

Witness #2

Your signature: _____ Print Name: _____ Today's Date: _____

Additional Instructions:

1. Let important people in your life know who you have named as your health care agent.
2. Make photo copies of this document and keep original in a safe place.
3. Give copies to: your agent, all doctors involved in your care, lawyer, minister, other family members.
4. Bring a copy with you when you are admitted to the hospital.