

# HEALTH CARE PROXY FORM

1) I, \_\_\_\_\_, hereby appoint

\_\_\_\_\_  
(Agent's name, home address and phone number)

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

2) **Optional:** Alternate Agent. If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint:

\_\_\_\_\_  
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. **Optional:** If you want this proxy to expire, state the date or conditions here. This proxy shall expire (specify date or conditions): \_\_\_\_\_

4) **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary): \_\_\_\_\_  
\_\_\_\_\_

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form.

## 5) **Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

Any needed organs and/or tissues

The following organs and/or tissues \_\_\_\_\_

Limitations \_\_\_\_\_

Failure to state wishes or instructions shall not be construed to imply a wish not to donate.

6) **Your Identification: (please print)** Your Name \_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

Your Address \_\_\_\_\_

7) **Statement by Witnesses:** (Must be 18 years of age or older and cannot be the health care agent or alternate.)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 (print) \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness 2 (print) \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

I have a health care proxy. In case of emergency, please notify my health care agent:

My Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

My Agent: \_\_\_\_\_

Agent's Address: \_\_\_\_\_

Agent's Phone: \_\_\_\_\_ Agent's E-mail: \_\_\_\_\_

Carry in your Wallet

