

Designation of Health Care Surrogate

In the event that I _____
Last Name First Name Middle Initial

have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures,

I wish to designate as my surrogate for healthcare decision:

Name Address City State/Zip Phone (_____) _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name Address City State/Zip Phone (_____) _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission or transfer from a health care facility. Additional instructions (optional): _____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate (so they may know who my surrogate is): _____

Witness # 1 (Any adult except Healthcare Surrogate)

Name Signature

Address City State/Zip Phone (_____) _____

Witness # 2 (Any adult except spouse, blood relative or Healthcare Surrogate)

Name Signature

Address City State/Zip Phone (_____) _____

Designator Signature _____ **Date** _____

Living Will

Declaration made this _____ I _____
Day Month Year Last Name First Name Middle Initial

willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and, _____ I have a terminal condition, or _____ I have an end-stage condition, or _____ I am in a persistent vegetative state, and if my attending or treating physician
Initial Initial Initial

and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures,

I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name Address City State/Zip Phone (_____) _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (optional): _____

Witness # 1 (Any adult except Healthcare Surrogate)

Name Signature

Address City State/Zip Phone (_____) _____

Witness # 2 (Any adult except spouse, blood relative or Healthcare Surrogate)

Name Signature

Address City State/Zip Phone (_____) _____

Designator Signature _____ **Date** _____



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