Healthcare Proxy

1. I, _____ residing at _____ _____ appoint _____ residing at _____ telephone (_____) _____ as my **healthcare agent** with authority to make health care decisions on my behalf.

(Optional: If this person is unavailable, unwilling, or incompetent to serve, I designate _____ residing at _____ telephone (____) _____ as my **alternate agent**.)

I intend this authority to become effective upon the determination by my attending physician that I lack the capacity to make or communicate healthcare decisions on my own behalf.

In exercising this authority, my agent shall make decisions in accordance with his or her assessment of my wishes. If my agent cannot determine my wishes, then he or she should make a choice for me based upon what he or she believes to be my best interests.

2. Check one:

☐ (a) I ***do*** want to include specific directions for my agent to follow and/or limits on his or her authority.
(*Please include these directions and limits below*)

☐ (b) I ***do not*** want to include specific directions for my agent to follow or limits on his or her authority.

3. I hereby revoke any prior healthcare proxy or "living will". Photocopies of this proxy shall have the same authority as the original.

4. Signature of Principal _____ Date _____

Witness Statement

We the undersigned witnesses are eighteen years of age or older and neither of us is named as the healthcare agent or alternate. To the best of our knowledge, the above named principal is at least eighteen years of age, of sound mind, and willingly executed this document in our presence under no constraint or undue influence.

Witness #1

Name _____

Address _____

Date _____ Signed _____

Witness #2

Name _____

Address _____

Date _____ Signed _____

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