

Health Care Proxy Form

I, _____, a resident of _____, _____, state of _____ (hereinafter known as "Principal"), pursuant to the laws of the state of _____, hereby appoint as my health care agent to make any health care decisions for me on my behalf, except as otherwise stated herein.

Name of Primary Agent

Address of Primary Agent

Email

Phone Number

If my Health Care Agent named above is not available, I name as an alternate Health Care Agent;

Name of Alternate Agent

Address of Alternate Agent

Email

Phone Number

The appointed Agent for Health Care shall make any and all health care decisions on my behalf, with exceptions to limitations indicated herein, during the following period:

Effectivity Start Date

Effectivity End Date

Duties and Powers

I give my Health Care Agent the authority to make all healthcare decisions on my behalf if I become incapable of making such decisions for myself, including but not limited to decisions concerning initiation, continuing, withdrawal or refusal of any life-prolonging care, treatment, service or procedure.

My Health Care Agent shall make health care decisions for me in accordance with my Health Care Agent's assessment of my wishes, including my religious and moral beliefs. If my wishes are unknown, my Health Care Agent shall make such decisions for me only in accordance with my Health Care Agent's assessment of my best interests.

My Agent may obtain any and all medical information, including confidential medical information, as I would be entitled to receive. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

Limitations

As to limitations, the restrictions are as follows:

Statement of Primary Health Care Agent (Optional)

I have been named by _____ (the "Principal") as the principal's Health Care Agent by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes at a time of possible incapacity, and I will try to give effect to the principal's wishes. I am not an operator, administrator or employee of a hospital, nursing home, rest home, Soldiers Home or other health facility where the principal is presently a patient or resident or has applied for admission; or if I am such a person, I am also related to the principal by blood, marriage or adoption.

Signature of Primary Health Care Agent: _____

Date: _____

Statement of Alternate Health Care Agent (Optional)

I have been named by _____ (the "principal") as the principal's Alternate Health Care Agent by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes at a time of possible incapacity, and I will try to give effect to the principal's wishes. I am not an operator, administrator or employee of a hospital, nursing home, rest home, Soldiers Home or other health facility where the principal is presently a patient or resident or has applied for admission; or if I am such a person, I am also related to the principal by blood, marriage or adoption.

Signature of Alternate Health Care Agent: _____

Date: _____

Name of Principal

Name of Agent

Signature of Principal

Signature of Agent

Date

Date

Declaration of Witnesses

I declare that as a witness, I am not appointed as an agent or alternate agent in this medical power of attorney. I declare that I am not, in any way, related to the principal by consanguinity or affinity. I am not an attending physician, a member of the physician's staff, or associated with a health care facility or its affiliates giving direct care to the principal. I have no claims whatsoever to the estate of the principal.

I declare that the parties who signed this document are personally known to me and of sound mind. I am aware that the said parties are acting on their own free will and free from any form of vitiated consent or coercion. The Principal herein has signed this document (or had asked another to sign on the Principal's behalf) in our presence.

Witness

Witness

Date

Date



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