Name:_____
Last First Middle Initial Date of Birth

In the event that I 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 health care decisions:

Name:_____

Address:_____

_____
City/State/Zip Code

Phone:_____

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

Name:_____

Address:_____

_____
City/State/Zip Code

Phone:_____

I fully understand that this designation will permit my designee to make health care decisions 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 to 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:

Name:_____

Name:_____

Signed:_____

Date:_____

Witnesses: 1._____

2._____

DESIGNATION OF HEALTH CARE SURROGATE