Designation of Health Care Surrogate

Name: _____
(Last name) *(First Name)* *(Middle Initial)*

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: _____ Zip Code: _____

Phone: _____ _____

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

Name: _____

Address: _____ 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 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 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. _____

(At least one witness must be neither a spouse nor a blood relative of the signatory.)