Designation of Health Care Surrogate

Name: _____ _____ _____
Last First 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 the cost of health care; to make the decision to give an anatomical gift and to authorize admission to or transfer from a health care facility,

Additional Instructions (Optional):

_____

_____

_____

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_____

3/00

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: _____

Address: _____

_____ Zip code: _____

Phone: _____

Name: _____

Address: _____

_____ Zip code: _____

Phone: _____

Signature _____ **Date:** _____

Witness*: _____

Address: _____

_____ Zip code: _____

Phone: _____

Witness*: _____

Address: _____

_____ Zip code: _____

Phone: _____

* Please note, the person designated as surrogate shall not act as a witness and at least one person who acts as a witness shall neither be the principal's spouse or blood relative.