

DESIGNATION OF HEALTH CARE SURROGATE
of

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 Number: (_____) _____

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 Number: (_____) _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, 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	Address	Phone Number.
1.	_____	_____
2.	_____	_____
3.	_____	_____

Signed: _____

Date: _____

Witnesses:

Signature	Printed Name	Address	Phone Number.
1.	_____	_____	_____
2.	_____	_____	_____