Designation of Health Care Surrogate

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I _____(Name) wish to designate, as my surrogate for healthcare decision:

Name:_____

Street Address:_____City:_____State:_____Zip:_____ Phone:_____

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

Name:_____

Street Address:_____City:_____State:_____Zip:_____ Phone:_____

I fully understand that this designation will permit my designee to make Healthcare decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care, and to authorize my admission to or transfer from a healthcare facility.
Additional instructions (optional):_____
_____
I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility.

Patient Signed:_____ **Date:**_____

Witness Name:_____ Witness Name:_____

Date:_____ Date:_____

Witness Signature 1:_____ ***Witness Signature 2:*** _____

Living Will

Declaration made this____ day of _____(20__), I _____, willfully voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set for below, and I do hereby declare that, if at any time I am incapacitated and:
_____ (Patient initial) I have a terminal condition, or
_____ (Patient initial) I have an end-stage condition, or
_____ (Patient initial) I am in a persistent vegetative state,
and if my primary physician and another consultant physician have determined that there is no reasonable medical probability of my recovery from such a condition, I direct. Life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.
I do____, I do not____ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of Life-prolonging procedures, I wish to designate, as my surrogate to carry out the provision of this declaration:

Name:_____

Street Address:_____City:_____State:_____Zip:_____ Phone:_____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.
Additional instructions (optional):_____
_____

Patient Signed:_____ **Date:**_____

Witness Signature 1:_____ ***Witness Signature 2:***_____

Street Address_____ Street Address:_____

City: _____State:_____ City: _____State:_____

Phone:_____ Phone:_____