## Appointment of My Health Care Representative

I (print), _____, born (date of birth) _____, understand that, as a capable adult, I have the right to make decisions about my health care. If there is a time, due to incapacity, that I am unable to make informed consent regarding health care decisions, I instruct those caring for me to seek direction from the **Health Care Representative** I appoint in this document. This person knows my values, preferences and health care wishes, and has legal authority to make any and all health care decisions on my behalf if I am unable to do so myself.

I appoint:

_____ _____

Print name Phone

If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions, and lack the capacity to make and communicate informed decisions regarding my health, **my Health Care Representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, and (2) make the decision to provide, withhold or withdraw life support systems.**

I direct my Health Care Representative to make decisions on my behalf in accordance with my wishes as stated in a living will, or as otherwise known to my Health Care Representative. In the event my wishes are not clear, or a situation arises that I did not anticipate, my Health Care Representative may make decisions in my best interests, based upon what is known of my wishes and preferences. **Nothing is to be done or omitted with the intention of taking my life.**

If this person is unwilling or unable to serve as my Health Care Representative, or is divorced or legally separated from me, or has died, I appoint the following individuals as alternates:

_____ _____

First alternate (print name) Phone

_____ _____

Second alternate (print name) Phone

This appointment is made, after careful consideration, while I am of sound mind.

x _____ _____

Signature Date

## Witnesses' Statement

This document was signed in our presence by _____, the author of this document, who appears to be eighteen years of age or older; is of sound mind; is able to understand the nature and consequences of health care decisions at the time this document is being signed; and is under no duress, fraud or improper influence. We have witnessed this document together in the author's presence and at the author's request.

x _____ x _____

Witness' signature Witness' signature

_____ _____

Witness' name (Printed) Witness' name (Printed)

_____ _____

Address (Number/Street) Address (Number/Street)

_____ _____ _____ _____

City/State Phone City/State Phone