HEALTH CARE PROXY

1. I, _____, hereby appoint the following person as my HEALTH CARE AGENT, to make any and all health care decisions for me except for any restrictions I have noted below. This Proxy shall take effect when and if I become unable to make my own health care decisions.

_____ _____
Health Care Agent Phone

_____
Address

_____

2. _____ _____
Alternative Health Care Agent Phone

_____
Address

_____

3. Optional instructions or limitations on the Health Care Agent's authority, if any:

_____

_____

4. Unless I revoke it, this proxy shall remain in effect indefinitely (or until the date or condition stated below, if any).

_____

_____

_____

5. Your Health Care Agent will not be able to make decisions about Administration of artificial nutrition and hydration unless you make your own wishes known.

If I cannot eat or drink enough because of my irreversible medical conditions:

_____ I DO _____ I DO NOT

want artificial nutrition (intravenous or tube feeding) or hydration (intravenous fluids).

6. _____
Patient Signature Date

_____
Address

_____
Address

7. I hereby certify that I am over 18 years of age, and that the person who signed this Proxy appeared to do so willingly and free from duress and that he or she signed (or asked another to sign for him or her) this Proxy in my presence.

_____
Witness Date

_____
Printed Witness Name

_____
Witness Date

_____
Printed Witness Name