Designation of Health Care Surrogate

of

____ (Name)

Should I become comatose, incompetent or otherwise mentally or physically incapable of communication, I designate the following as my surrogate, to make health care decisions for me, including decisions to apply for public benefits, and authorize my admission or transfer to a health care facility.

____________________________________ (Name)
____________________________________ (Address)
____
____________________________________ (Phone)

If that person is unwilling or unable to act, then as my alternate surrogate:

____________________________________ (Name)
____________________________________ (Address)
____
____________________________________ (Phone)

(Additional Directions)

Signed this ______ day of __________________, 20 _____.

____________________________________ (Signature)
____________________________________ (Address)
____

The declarant is personally known to me and I believe him/her to be of sound mind. (The witnesses cannot be the health care surrogate; only one witness can be a spouse or relative of the signer.)

____________________________ (Witness)
____________________________ (Witness)

____________________________ (Address) ____________________________
(Address)

____________________________ (Phone) ____________________________
(Phone)