HEALTH CARE PROXY

I, _____ (the principal), of _____, _____ County, Massachusetts, pursuant to Massachusetts General Laws Chapter 201D, appoint the following person to be my Health Care Agent:

Name: _____

Address: _____

If my Health Care Agent named above is not available, I name as alternate Health Care Agent:

Name: _____

Address: _____

Phone: _____

I give my Health Care Agent authority to make all health care decisions on my behalf if I become incapable of making such decisions for myself. I place the following limitations on the authority of my Health Care Agent:

NONE

_____
_____
_____

My Health Care Agents authority to act on my behalf shall exist only for the period during which my attending physician determines that I lack capacity to make or communicate health care decisions for myself.

Nothing in this Health Care Proxy shall preclude any medical procedures which my attending physician determines necessary to provide for my comfort or pain alleviation.

This Health Care Proxy shall be revoked upon my execution of a subsequent Health Care Proxy or upon my notification to my Health Care Agent or to a health care provider orally or in writing or by my performance of any other act evidencing a specific intent to revoke this Health Care Proxy.

I have signed a living will, a copy of which is attached to this Health Care Proxy, as guidance to my Health Care Agent.

I sign this Health Care Proxy on _____, 2020 in the presence of two witnesses, neither of whom is my Health Care Agent or alternate.

_____
Name:

We witness the signing of this document by _____ on

_____2020 and state that she appears to be at least eighteen years

of age, of sound mind and under no constraint or undue influence.

Witness _____ Witness_____

Printed Name _____ Printed Name _____

Address_____ Address_____

_____ _____