DESIGNATION OF HEALTH CARE SURROGATE

(DURABLE POWER OF ATTORNEY FOR HEALTHCARE)

In the event that I, Name (First/Last);_____ Date Of Birth: ____/____/_____

Address: _____ Phone #:_____, have been determined by my physician(s) to be incompetent / incapacitated (lack the ability) to provide informed consent for medical treatment and surgical and diagnostic procedures including, but not limited to the withholding, withdrawal, or continuation of life prolonging procedures, **I wish to designate as my surrogate to make health care decisions**:

Name: _____/_____ **Phone #** (w) _____
First Name / Last Name **Relationship** (h) _____
Address:_____

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

Name: _____/_____ **Phone** # (w) _____
First Name / Last Name **Relationship** (h) _____
Address:_____
_

Additional instructions (optional):_____-
____

I fully understand that this designation will permit my decisionmaker to make all health care decisions on my behalf until I regain the ability to make health care decisions. The healthcare decisions may also include if necessary the decisions to withhold, withdraw, or continue life prolonging procedures. My decisionmaker may also authorize my admission to or transfer from a health care facility and also apply for public assistance on my behalf. This designation is to remain in effect during any incapacity or incompetency I may experience. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

1st Witness (required):_____ **Signatur**e:_____

2nd Witness (required):_____ **Date**: _____/_____/_____

LIVING WILL

I willfully and voluntarily make known my desire that my dying **not** be artificially prolonged under the following circumstances. **If at any time I am incompetent / incapacitated and have a terminal condition and / or am in a persistent vegetative state, and / or have an end stage condition and if my attending / treating physician and a consulting physician have determined that there is no medical probability of my recovery from such condition(s), I direct that life- prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying**. I request to 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 _____ (initial) or I do not _____ (initial) want to be given nutrition and / or hydration artificially by a feeding tube or by intravenous feedings when it would serve only to prolong artificially the process of dying.

I also desire to have life prolonging procedures withheld / withdrawn when: (optional)

_____ (Initial) Due to a debilitating disease condition in which I have no reasonable probability of recovering, I cannot communicate or interact purposely with others.

_____ (Initial) Specify Other Condition: _____.

Additional instructions (Optional): _____.

I request that my Living Will be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. If I am pregnant and this is known to my physician(s), this Living Will shall have no force or effect during the course of my pregnancy.

I understand the full meaning of this Living Will, and I am emotionally and mentally competent to make these declarations.

1st Witness (required): _____ **Signature**:
_____

2nd Witness (required):_____ **Date:** _____/_____/_____ (04/07)