Designation of Health Care Surrogate

Name _____

In the event I have been determined to be incapacitated, unable to provide informed consent for medical treatment including diagnostic and surgical procedures, I wish to designate, as my surrage for health care decisions:

Name_____

Street Address_____

City_____ State_____ Zip_____

Phone_____

I fully understand that this designation will permit my designee to make health care decision and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of healthcare; and to authorize my admission to transfer from a health care facility.

Additional Instructions (optional):

_____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____

Name_____

Signed_____

Witnesses 1. _____

Witnesses 2. _____