

**DIRECTIONS**

Patient's name.  
Today's date.

These persons should include your designated health care surrogate and at least one of the following: physician, attorney, authorized representative, family, friend, significant other or caregiver.

Your name and signature.

Both witnesses must see you sign this form at the same time. Your health care surrogate(s) cannot be a witness. Only one witness can be a husband, wife or blood relative.

You must provide a copy of this form to your health care surrogate. You may provide copies of this form to your physician, attorney, authorized representative, family, friends, significant other and caregiver.

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(please print)

If I am not able to make decisions or express my wishes concerning medical treatment and surgical or diagnostic procedures, I appoint the following person(s) to do so for me:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

If my health care surrogate is unwilling or unable to perform their duties, I wish to designate my alternate as:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

My health care surrogate can make my health care decisions. They may provide, withhold or withdraw care on my behalf; or apply for public benefits to reduce the cost of health care; and authorize my admission to or transfer from a health care facility.

**I have a Living Will.**     Yes     No

I state this appointment is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons so they may know who my health care surrogate is:

Name(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Name(s): \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
**Patient Name** (please print)

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
#1 Witness Name (please print)

\_\_\_\_\_  
#1 Witness Signature

\_\_\_\_\_  
#1 Witness Address

\_\_\_\_\_  
#1 Witness Phone Number

\_\_\_\_\_  
#2 Witness Name (please print)

\_\_\_\_\_  
#2 Witness Signature

\_\_\_\_\_  
#2 Witness Address

\_\_\_\_\_  
#2 Witness Phone Number



# DESIGNATION OF HEALTH CARE SURROGATE