HEALTH CARE SURROGATE DESIGNATION FORM

Name _____
LAST FIRST MIDDLE

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

Name: _____
Address: _____
Phone Number: _____

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

Name: _____
Address: _____
Phone Number: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or 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 health care 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: _____
Address: _____
Name: _____
Address:_____
Signed:_____ Date: _____
Witness: 1._____ Witness: 2._____

- Witnesses cannot be designated surrogate or alternate. One of the witnesses cannot be a spouse or blood relative.

ACCEPTANCE OF SURROGATE DESIGNATION

I, _____, do hereby accept responsibility to act as health care surrogate for _____ should he/she become incapacitated.

Current Address: _____
Signed: _____ Date:_____