

**FORM FOR APPOINTING HEALTH CARE REPRESENTATIVE AND  
ALTERNATE HEALTH CARE REPRESENTATIVE  
(STATE OF OREGON)**

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a health care representative.

- If you have completed a form appointing a health care representative in the past, this new form will replace any older form.
- You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.
- If you become too sick to speak for yourself and do not have an effective health care representative appointment, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635(2).

**1. ABOUT ME.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Telephone numbers: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

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

E-mail: \_\_\_\_\_

**2. MY HEALTH CARE REPRESENTATIVE.**

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

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

Telephone numbers: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

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

E-mail: \_\_\_\_\_

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative's appointment.

First alternate health care representative:

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

Telephone numbers: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

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

E-mail: \_\_\_\_\_

Second alternate health care representative:

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

Telephone numbers: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

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

E-mail: \_\_\_\_\_

**3. MY SIGNATURE.**

My signature: \_\_\_\_\_ Date: \_\_\_\_\_

**4. WITNESS.**

COMPLETE EITHER A OR B WHEN YOU SIGN.

A. NOTARY:

State of \_\_\_\_\_

County of \_\_\_\_\_

Signed or attested before me on \_\_\_\_\_, 2\_\_\_\_\_, by \_\_\_\_\_.

\_\_\_\_\_  
Notary Public - State of Oregon

**B. WITNESS DECLARATION:**

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternative health care representative, and I am not the person's attending health care provider.

Witness Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**5. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.**

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name: \_\_\_\_\_

Signature or other verification of acceptance: \_\_\_\_\_

Date: \_\_\_\_\_

First alternate health care representative:

Printed name: \_\_\_\_\_

Signature or other verification of acceptance: \_\_\_\_\_

Date: \_\_\_\_\_

Second alternate health care representative:

Printed name: \_\_\_\_\_

Signature or other verification of acceptance: \_\_\_\_\_

Date: \_\_\_\_\_