

Designation of Healthcare Surrogate

Name _____
 LAST FIRST MI

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 healthcare decisions:

Name _____
Address _____ City _____
State/Zip _____ Phone _____

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

Name _____
Address _____ City _____
State/Zip _____ Phone _____

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

NUTRITION AND HYDRATION

___ I **do** ___ **do not** desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

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 will know who my surrogate is.

Name _____

Name _____

Name _____

Signed _____ Date _____

Witness Signature _____

Witness Signature _____

This form courtesy of Kolodinsky, Seitz and Tresher.