**HEALTH CARE PROXY**

*(Valid across all U.S. states – Check local laws for specific requirements)*

**1. DESIGNATION OF HEALTH CARE AGENT**

I, **[Full Name]**, residing at **[Address]**, hereby appoint:

* **Primary Health Care Agent:**
Name: **[Full Name]**
Address: **[Agent's Address]**
Phone: **[Agent's Phone]**

to make any and all health care decisions for me if I become unable to make my own medical decisions.

**2. ALTERNATE AGENT (OPTIONAL)**

If my primary agent is unable, unwilling, or unavailable to act, I appoint:

* **Alternate Health Care Agent:**
Name: **[Full Name]**
Address: **[Address]**
Phone: **[Phone]**

**3. DURATION OF PROXY**

This Health Care Proxy **remains in effect indefinitely** unless I revoke it or specify an expiration date.

☐ **This proxy shall expire on:** **[Date or Condition for Expiration]**

**4. INSTRUCTIONS & LIMITATIONS (OPTIONAL)**

If you want to provide instructions for your agent or **limit** their decision-making authority, specify them below:

Example:

* "I do not want to receive life-sustaining treatment if I am in a persistent vegetative state or terminal condition."
* "My agent may not consent to experimental treatments or clinical trials."
* "I wish to receive all available pain relief, even if it hastens my death."

☐ **Attach additional pages if necessary**

**5. ARTIFICIAL NUTRITION AND HYDRATION (OPTIONAL)**

To authorize your agent to make decisions regarding artificial nutrition and hydration (feeding tubes, IV fluids), you **must** state your wishes:

☐ **I authorize my agent to make decisions regarding artificial nutrition and hydration based on my wishes.**
☐ **I DO NOT wish to receive artificial nutrition and hydration if I am in a terminal or irreversible condition.**
☐ **Other Instructions:** **[Specify]**

**6. ORGAN AND TISSUE DONATION (OPTIONAL)**

Upon my death, I wish to make an **anatomical gift**:

☐ **Any needed organs and/or tissues**
☐ **Only the following organs/tissues:** **[Specify]**
☐ **I DO NOT wish to donate any organs/tissues**
☐ **I leave this decision to my agent**

**7. SIGNATURE & ACKNOWLEDGMENT**

I understand that this document allows my health care agent to make medical decisions on my behalf if I am unable to do so.

**Your Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Your Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Your Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. WITNESSES**

*(Must be signed by two adult witnesses who are NOT your appointed health care agent or alternate agent.)*

**Witness 1**

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness 2**

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. NOTARY ACKNOWLEDGMENT (OPTIONAL, REQUIRED IN SOME STATES)**

STATE OF **[Your State]**
COUNTY OF **[Your County]**

On this \_\_\_ day of \_\_**, 20**, before me, a Notary Public, personally appeared **[Your Name]**, known to me or proven by satisfactory evidence to be the person who signed this document.

**Notary Public Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Notary Public Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_