Health Care Proxy

(1) I, _____, hereby appoint:
(name)

_____
(name, home address and telephone number of agent)

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. **My agent does know my wishes regarding artificial nutrition and hydration.**

This Health Care Proxy shall take effect in the event I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows.

_____

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent.

_____
(name, home address and telephone number of agent)

_____

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

_____

(5) Signature_____ Date _____

Address _____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as proxy by this document.

Witness 1 _____

Address _____

Witness 2 _____

Address _____