HEALTH CARE PROXY

(_____)

In the event that the time comes and I am incapacitated to the point that I am no longer able to actively take part in decisions for my own life, and I am unable to direct my healthcare physician as to my own medical care, I hereby authorize this document as my Health Care Proxy to stand as a testament of my wishes.

I, _____, residing at _____, _____ in the County of _____ in the State of _____ in the zip code _____ and whose telephone number is _____, being of sound mind, of the age of consent and acting willingly and without duress, fraud or undue influence, herein direct that the instructions provided herein are to be recognized as a formal statement of my desires with regards to my health care and medical treatment, and as such I hereby voluntarily declare and make this designation with regards to my Health Care Proxy. These instructions and directives shall be binding upon all involved to the fullest extent allowable by law.

DESIGNATION OF HEALTH CARE PROXY

I herein designate _____, residing at _____, _____, _____ _____ and whose telephone number is _____, as my Proxy and agent to make any and all healthcare decisions on my behalf should I ever be diagnosed with a terminal illness, disease, injury, or should I become incapacitated or permanently unconscious (in a coma or persistent vegetative condition) where I would remain permanently unable to make decisions.

HEALTH CARE PROXY'S AUTHORITY COMMENCEMENT

My Proxy's authority shall become effective upon my primary or attending physician's determination that I lack the capacity to make my own healthcare decisions, unless otherwise stipulated below.

PROXY'S GENERAL POWERS

My Health Care Proxy shall have the power to make healthcare and medical treatment decisions on my behalf if my attending and/or primary physician makes the determination that I am unable to make said decisions.

LIFE-SUSTAINING MEDICAL TREATMENT

Should any of the aforementioned events occur, I wish to leave the following directives regarding the treatment and procedures which may be used, withheld or withdrawn:

- I wish to _____ cardiac resuscitation (CPR) in an attempt to try and prolong my life.

- I wish to _____ life-support (e.g., respirators, ventilators) used in an effort to replace or support my natural breathing.

- I wish to _____ tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

- I wish to _____ blood or blood products.

- I wish to _____ any form of surgery or invasive diagnostic tests.

- I wish to _____ kidney dialysis.

- I wish to _____ antibiotics or medication in an attempt to try and prolong my life.

- I wish to _____ maximum pain relief medication.

I understand that if I do not specifically indicate my preferences above regarding any of the forms of treatment, I may be subjected to that form of treatment.

DECLARANT STATEMENT AND SIGNATURE

This instrument shall be governed by the laws of _____, and I respectfully request that it be honored in any state in which I may reside at the time that this Health Care Proxy shall take effect.

By signing below, I certify that I am fully aware and completely understand the contents of this document, and that I am of sound body and mind. Furthermore, I am of the legal age of consent and not under undue influence, fraud or duress.

WITNESSES

This Health Care Proxy must be signed by two adult witnesses that are personally present when I sign this document.

WITNESS STATEMENT

I certify that I am of 18 years of age or older and that I know the Declarant personally or have been provided with valid identification to his/her identity and believe him/her to be of sound mind and under no duress, fraud or undue influence. The Declarant has had the opportunity to read this document and has signed or acknowledged his/her signature or mark in my presence.

Under penalty of perjury I declare that I am not related to the Declarant by blood, marriage or adoption, nor am I responsible for his/her medical care or costs. Furthermore, I am not the primary or attending physician or an employee of the physician or other health care provider or current care facility for the Declarant. I also attest that I am not an employee of any life or health insurance provider, nor am I involved with the direct physical care of the Declarant. Further, I have no claim to the Declarant's estate, and to the best of my knowledge, I am not entitled to any part of the Declarant's estate upon his/her death with any will now in existence or by any other process of law.

_____ _____

(Declarant Signature) (Date)

NOTARY PUBLIC
CERTIFICATE OF ACKNOWLEDGMENT

STATE OF _____)
)
COUNTY OF _____)

On this date, _____, the Declarant, _____, personally appeared before me and having provided verifiable identification to be the Declarant whose name is subscribed to this instrument and acknowledged to me that s/he executed the same in his/her capacity, and that by his/her signature on the instrument, executed the instrument.

I declare that s/he appears to be of sound mind and not under or subject to duress, fraud or undue influence, that s/he acknowledges the execution the same to be his/her voluntary act and deed, and that I am not the proxy, attorney-in-fact, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by any other means or process of law.

WITNESS my hand and seal.

_____
(Notary Signature)

My Commission Expires: _____
(Date)