

APPOINTMENT OF HEALTH CARE AGENT
(Supplemental to a Living Will)

I appoint _____(Name)
to be my health care agent. If my attending physician determines that I am
unable to understand and appreciate the nature and consequences of health
care decisions and to reach and communicate an informed decision regarding
treatment, my health care agent is authorized to:

- (1) Convey to my physician my wishes concerning the withholding or
removal of life support systems.
- (2) Take whatever actions are necessary to ensure that my wishes are
given effect.

If this person is unwilling or unable to serve as my health care agent, I appoint:
_____(Name)

to be my alternative health care agent.

This request is made, after careful reflection, while I am of sound mind.

Signature _____ Date _____

This document was signed in our presence, by the above-named
_____(Name), who appeared to be
eighteen years of age or older, of sound mind and able to understand the nature
and consequences of health-care decisions at the time the document was
signed.

Witness _____ Address _____

Witness _____ Address _____

Notarizing (Optional) – On Reverse Side

