HEALTH CARE PROXY

OF

I, _____, do hereby appoint, _____ _____ residing at _____, cell phone ___ _____, as my health care agent to make any and all health care decisions for me. This health care proxy shall take effect in the event that I become unable to make my own health care decisions.

If the person I appoint is unable or unavailable to act as my health care agent, I hereby appoint

telephone number , as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely.

I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions: I affirm that I do not draw a distinction between nutrition and hydration and any other kind of life-sustaining treatment, and expressly authorize my health care agent and substitute health care agent, in his or her unrestricted discretion, to direct that artificial nutrition and hydration be withdrawn or withheld from me when my agent or successor agent believes it is in my best interest to do so.

I delegate to my agent the power and authority to select, employ and discharge health care personnel, such as physicians, nurses, therapists, hospice care and home health care providers, and other medical professionals; to admit or discharge me (including transfer from another facility) from any hospital, hospice, nursing home, adult home or other medical care facility; and to apply for public benefits to defray the cost of health care, and to contract in my name and on my behalf for all health care services, including without limitation medical nursing

and hospital care, as my agent may deem appropriate. I confirm that I shall be and remain personally liable or the payment of all such care and services to the same extent as if I had personally contracted therefore.

I wish to live out my days at home rather than in a hospital, if it does not jeopardize the chance of my recovery to a meaningful and conscious life and does not impose undue burden on my family.

I further authorize my agent to request, receive and review any information regarding my physical or mental health, including without limitation medical and hospital records; to execute on my behalf any releases or other documents that may be required in order to obtain this information; and to consent to the disclosure of this information. I authorize my agent to execute on my behalf any documents necessary or desirable to implement the health care decisions that my agent is authorized to make pursuant to this document, including without limitation all documents pertaining to a refusal to permit medical treatment, or authorizing the leaving of a medical facility against medical advice, or any waivers or releases from liability required by a physician or health care provider.

I further authorize my agent to make an anatomical gift of all of my organs as needed for organ and/or tissue donation.

DATED: _____

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her free will. He or she signed this document in my presence.

_____ _____

WITNESS ADDRESS

_____

WITNESS

ADDRESS