# DESIGNATION OF HEALTHCARE SURROGATE AND LIVING WILL

***Please fill out this form to choose someone to make your healthcare decision if you are not able to. If you don't complete the form, the institution is required by law to appoint someone. It is better for you to do so. We strongly recommend it.***

In the event I become unable to make healthcare decisions or to give informed consent for medical treatment or tests, I designate as my decision maker or surrogate:

Name:_____Relationship:_____

Phone:_____ Address: _____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate surrogate:

Name:_____Relationship:_____

Phone:_____Address:_____

☐ I have ☐ I have not formulated a Living Will before this admission

Additional instructions (optional):_____

_____

**Sign this form and have two witnesses sign it. Give copies to your doctor and family members. Bring the form to the hospital when you are admitted.**

I understand that the surrogate (1) shall have authority to act for me and make healthcare decisions for me during my incapacity; (2) is to consult with appropriate health care providers to consent or refuse medical interventions; and (3) is required to make sure health care decisions as she/he believes I would have made if I were able.

_____ _____ _____ / _____

Patient Signature Date/Time Witness to Signature Only / Witness to Signature Only

**ONLY ONE WITNESS MAY BE A SPOUSE OR BLOOD RELATIVE; A SURROGATE CANNOT BE A WITNESS**

_____ / _____

Print Name/Relationship / Print Name/Relationship

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**LIVING WILL**

***Please complete this form or provide a document of your own. You may request help to complete the form.***

Patient Name:_____

Last Name First Name Middle Initial

I willfully and voluntarily express my desire that my dying not be artificially prolonged. This form should be honored when I am incapacitated and have a terminal condition or end-stage condition or am in a persistent vegetative state, and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition. In such circumstances, I direct that life prolonging procedures by withheld or withdrawn, and that I be permitted to die naturally and receive medication or medical procedures necessary to make me comfortable or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment.

I understand the importance and consequences of this declaration, and I am emotionally and mentally able to make this declaration.

**Sign this form and have two witnesses sign it. Give copies to your doctor and family members. Bring the form to the hospital when you are admitted.**

_____ _____ _____ / _____

Patient Signature Date/Time Witness to Signature Only / Witness to Signature Only

_____ / _____

Print Name/Relationship / Print Name/Relationship