You must provide a copy of this form to your health care surrogate. You may provide copies of this form to your physician, attorney, legal representative, family, friends, significant other and caregiver.

Patient Name: ______________________________ Today's Date: ____/____/____

If I am not able to make decisions or express my wishes concerning medical treatment and surgical and diagnostic procedures, I appoint the following person(s) to do so for me:

Name: ______________________________
Street Address: ______________________________
City: ______________________________ State: ________ Zip: ____________
Phone: ______________________________

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

Name: ______________________________
Street Address: ______________________________
City: ______________________________ State: ________ Zip: ____________
Phone: ______________________________

My surrogate can make health care decisions and provide, withhold, or withdraw consent on my behalf; or apply for public benefits to reduce the cost of health care; and authorize my admission to or transfer from a health care facility.

I have a living will. ❐ **Yes** ❐ **No**

I state that this appointment is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons so they may know who my surrogate is:

[These persons should include your health care surrogate and at least one of the following: your physician, attorney, legal representative, family, friend, significant other or caregiver.]

Name(s): ______________________________

Name(s): ______________________________

______________________________ ______________________________
Patient Name (please print) **Patient Signature**

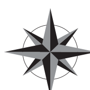
[Both witnesses must see you sign this form at the same time. Your health care surrogate(s) cannot be a witness. Only one witness can be a husband, wife or blood relative.]

______________________________ ______________________________
#1 Witness Name (please print) #1 Witness Signature

______________________________ ______________________________
#1 Witness Address #1 Witness Phone Number

______________________________ ______________________________
#2 Witness Name (please print) #2 Witness Signature

______________________________ ______________________________
#2 Witness Address #2 Witness Phone Number



Good Shepherd HOSPICE
Initially Licensed in 1984
Making the Most of Life

DESIGNATION OF HEALTH CARE SURROGATE

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