COMPASSIONATE FAMILY MEDICINE
HEALTH CARE PROXY

(1) I_____

hereby appoint _____
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, including decisions about artificial nutrition and hydration, except to the extent that I stat otherwise. This proxy shall take effect when and if I become unable to make my own health decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

_____

_____

_____

(Unless your agent knows your wishes about artificial nutrition and hydration [feeding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration.)

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____
(name, home address and telephone number)

_____

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

_____

(5) Signature _____Date: _____

Address _____

Statement by Witnesses (must be 18 or older)

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 own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1: _____

Address: _____

Witness 2: _____

Address: _____

CFM; LG; 02/15/2018