Health Care Proxy Advance Directive

Principal Information

Full Name

Address

Phone

Date of Birth

Designation of Health Care Agent

Agent's Full Name

Agent's Address

Agent's Phone

Alternate Agent (optional)

Name, Address, Phone

Statement of Authority Granted

I hereby appoint my health care agent indicated above to make all health care decisions on my behalf if I become unable to make such decisions myself.

Additional Instructions (optional)

Limitations on Agent's Authority (optional)

Principal's Signature

Date

Print Name

Witnesses

Witness #1 Signature

Print Name

Date

Witness #2 Signature

Print Name

Date