

Health Care Proxy Appointment Form

Full Name of Principal (Person Appointing Proxy):

Date of Birth:

Address:

I hereby appoint the following person as my Health Care Agent:

Name of Health Care Agent:

Relationship:

Phone:

Address:

Alternate Health Care Agent (Optional):

Name:

Relationship:

Phone:

Address:

Instructions and Limitations (Optional):

(Insert any special instructions or limitations regarding your health care here)

Duration:

This Health Care Proxy shall remain in effect until revoked by me in writing.

Signatures

Signature of Principal:

Date:

Print Name:

Witnesses

Witness #1 Signature:

Print Name:

Witness #2 Signature:

Print Name:

Date:

Date:
