Durable Power of Attorney for Health Care for the Appointment of a Health Care Representative (Proxy Directive)

*** I_____ (print name here) do hereby appoint:
(Name)_____(City)_____(State)_____
(Zip)_____

to be my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining treatment if I am unable to make such decision myself. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear or if a situation arises that I did not anticipate my health care representative is authorized to make decisions in my best interest.

If the previously named person is unable, unwilling, or unavailable to act as my health care representative, I appoint the following as my alternate health care representative:

Name _____ Telephone _____
Address _____
City _____ State _____ Zip Code _____

I sign this document knowingly and after careful deliberation this _____ day of _____, 20_____.

** Signature _____
Address _____
City _____ State _____ Zip Code _____

Witnesses:

Witness Signature _____ Witness Name (print) _____
Address _____
City _____ State _____ Zip Code _____

Witness Signature _____ Witness Name (print) _____
Address _____
City _____ State _____ Zip Code _____

Sworn and Subscribed before me on the _____ day of _____, 20_____

_____
Notary Public – State of New Jersey