DR. HARRY PEPE & ASSOCIATES
FAMILY MEDICINE SINCE 1959

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DESIGNATION OF HEALTH CARE SURROGATE

Patient Name: ____

If I have been determined to be incapacitated to provide informed consent for medical treatment, surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: ____
Street Address: ____
City: ________________________________ State: __________ Zip: ________
Phone: ______________________________

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

Name: ____
Street Address: ____
City: ________________________________ State: __________Zip: _________
Phone: ______________________________

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional):____

I further affirm that this designation 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 other than my surrogate, so they may know who my surrogate is.

Name (printed) : ____
Signature: ____
Date: ______________________

Witnesses 1. ____
2. ____

At least one witness must not be a husband or wife or a blood relative of the principal.