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, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

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

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

LIVING WILL

This Living Will has been prepared to conform to the law in the State of New York, as set forth in the case of In re *Westchester County Medical Center, 72 N.Y.2d 517 (1988). In that case the Court approved of the use of a Living Will, stating that the "ideal situation is one in which the patient's wishes were expressed in some form of writing, perhaps a 'living will.'"*

I, YOUR NAME , being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in **an incurable or irreversible mental or physical condition with no reasonable expectation of recovery.**

These instructions apply if I am a) **in a terminal condition;** b) **permanently unconscious;** or c) **minimally conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.**

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.
While I understand that I am not legally required to be specific about future treatments, **if I am in the condition(s) described above I feel especially stronqly about the followinq forms of treatment:**

- I do not want cardiac resuscitation.
- I do not want mechanical respiration.
- I do not want tube feeding.
- I do not want antibiotics.
- I do want maximum pain relief.

Other directions (insert personal instructions):

These directions express my legal right to refuse treatment; under the law of New York. I intend my instructions to be carried out, unless I have rescinded them in writing or by clearly indicating that I have changed my mind.

Your Signature DATE

Witness 1 SIGNATURE DATE

ADDRESS CITY STATE

Witness 2 SIGNATURE DATE

ADDRESS CITY STATE