

Appointment of Health Care Proxy

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby appoint:

[Proxy's Full Name]

Address: [Proxy's Address]

Phone Number: [Proxy's Phone Number]

As my Health Care Proxy to make medical decisions on my behalf if I become unable to make such decisions myself.

This appointment is effective immediately and will remain in effect until I revoke it in writing.

In witness whereof, I have signed this document on [Insert Date].

[Your Signature]

[Your Printed Name]

Witnessed by:

[Witness Signature]

[Witness Printed Name]