

Health Care Decision-Maker Nomination

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], hereby nominate [Nominee's Name] as my Health Care Decision-Maker for any medical decisions that may arise should I become unable to make these decisions myself.

Contact Information for the Nominee:

- Phone: [Nominee's Phone]
- Email: [Nominee's Email]
- Address: [Nominee's Address]

This nomination is effective immediately and remains in effect until revoked by me in writing.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Address]

[Your Phone]

[Your Email]