HEALTH CARE PROXY

I, _____, of _____
(name) (address)

_____,
do hereby appoint the following individual as my health care agent ("agent"):

PRIMARY APPOINTMENT

Name: _____ Home Phone: _____

Relationship: _____ Cell Phone: _____

Address: _____

to make any and all health care decisions for me which I, myself, could make in person while competent and possessed of health care decision-making capacity. This proxy shall remain in effect indefinitely.

ALTERNATE APPOINTMENT

If the person named above is unable, unwilling or unavailable to act as my health care agent, then I hereby appoint the following individual:

Name: _____ Home Phone: _____

Relationship: _____ Cell Phone: _____

Address: _____

This health care proxy shall take effect if and when I become unable to make my own health care decisions.

In respect of each health care decision made for me by my agent, it is my wish and direction that my agent be guided solely by my agent's belief as to what my own decision would have been in the same circumstances. My agent knows my wishes concerning life-sustaining treatment, including, without limitation, nutrition and hydration of any kind, artificial and otherwise, and I direct that decisions regarding such life-sustaining treatment be within the unrestricted scope of my agent's authority as to my health care. I do however direct that my lips be kept moist for my comfort.

My agent may give informed consent for health care decisions on my behalf and, as my Personal Representative under the Health Insurance Portability and Accountability Act of 1996, receive my protected health information and authorize the disclosure and use of my protected health information as provided in 45 CFR Part 164.

Dated: _____, 2022 Signature: _____

Printed: _____

Statement by Witnesses: We each 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	Address Line 1
	Address Line 2
Witness	Address Line 1
	Address Line 2

LIVING WILL

TO MY FAMILY, all physicians, hospitals and other health care providers and any court or judge:

I, _____, of _____
(name) (address)

_____,

declare that after thoughtful consideration, I have decided that I wish to forego all life-sustaining treatment if I shall in the future sustain substantial and irreversible loss of mental capacity AND

(a) I am unable to eat and drink without assistance, and tubes or other artificial means are required to feed me, and it is highly unlikely that I will ever be able to eat and drink without artificial feeding.

OR

(b) I have an incurable or irreversible condition which is likely to cause my death within a relatively short time.

Such loss of mental capacity by me, and the existence of either (a) or (b), as described above is sometimes referred to herein as a "triggering event." All life-sustaining treatment shall be withheld or withdrawn from me upon the occurrence of a triggering event whether or not I am at times conscious, alert or free from pain. The term "life-sustaining treatment" is intended to include, without limitation, nutrition and hydration of any kind, artificial or otherwise whenever that term is used in this instrument.

As used herein the term "an incurable or irreversible condition which is likely to cause my death within a relatively short time" shall mean a condition which would, without the administration of medical procedures which serve only to prolong the process of dying, result in my death within a relatively short time.

No cardiopulmonary resuscitation shall be administered to me if I sustain cardiac or pulmonary arrest following the occurrence of a triggering event. Effective upon the occurrence of a triggering event, I consent to an order not to resuscitate, as that term is defined in §2961 of the Public Health Law of the State of New York ("DNR order"), and direct that a DNR order be placed in my medical record maintained by each physician, hospital and other health care provider furnishing medical care for me at that time.

I recognize that when life-sustaining treatment is withheld or withdrawn from me, I will surely die of dehydration and malnutrition within days or weeks. I direct that all available medication for the relief of pain and for my comfort shall be administered to me after life-sustaining treatment is withheld or withdrawn even if I am rendered unconscious and my life is shortened thereby.

I have executed this instrument while in full command of my faculties in order to furnish clear and convincing proof:

- Of the strength and durability of my determination to forego life-sustaining treatment in any of the circumstances referred to herein;

- Of my firm and settled conviction that I am entitled to forego such treatment in the exercise of my constitutional and common law rights to determine the course of medical treatment; and
- Of my belief that my right to forego such treatment is paramount to any responsibility of any health care provider or the authority of any court or judge to attempt to force unwanted medical care upon me.

I direct that my family, all physicians, hospitals and other health care providers and any court or judge honor my decision not to artificially extend my life by mechanical means, and if there is any doubt as to whether or not life-sustaining treatment is to be administered to me after I have sustained substantial and irreversible loss of mental capacity, such doubt is to be resolved in favor of withholding or withdrawing such treatment. I direct that my treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment. These directions express my legal right to refuse treatment. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clear indication that I have changed my mind.

Dated: _____, 2022 Signature: _____

Printed: _____

Statement by Witnesses: We each 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 Address Line 1

_____

Address Line 2

_____ _____

Witness Address Line 1

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Address Line 2