HEALTH CARE PROXY

I appoint Agent having an address at as my agent to make all health care decisions for me, except to the extent I express otherwise.

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

NOTE: I hereby instruct my agent as follows:

NOTE: I hereby limit my agent's authority as follows:

NOTE:

I direct that my agent to make any and all health care decisions according to my instructions as stated above or as otherwise made known to him or her. I also direct my agent to conform to any limitations on his or her authority as stated above or as otherwise made known to him or her.

In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint having an address at .

It is understood that, unless I revoke it, this proxy will remain in effect indefinitely or until the date or occurrence of any condition I state below:

This proxy shall expire on _____ _____

_____

Signature Date

Address

I DECLARE THAT the person who signed or asked another to sign this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence and that person signed in my presence. I am not the person appointed as agent by this document.

Signature	Signature
Print Name	Print Name
Address	Address