APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I voluntarily appoint the following person as my health care representative. My representative is authorized to act for me in all matters of health care in accordance with IC 16-36-1 and IC 30-5 et. seq., except as otherwise specified below.

Appointed Health Care Representative	Address
Telephone Number	City
Social Security Number	State & Zip Code

I authorize my health care representative to make decisions in my best interest concerning consent to treatment and the withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician(s) and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others; to the extent they are available.

This appointment is to be exercised in good faith and in my best interest subject to the following terms and conditions:

This appointment becomes effective and remains effective if I am incapable of consenting to my health care. I do authorize my health care representative hereby appointed to delegate decision-making power to another.

Dated this _____ day of _____, year of _____

Signature	Street Address
Print Full Legal Name	City, County & State of Residence
Date of Birth	Social Security Number

I declare that I am an adult at least eighteen (18) years of age and that at the request of the above-named individual making the appointment, I witnessed the signing of this document by the Appointee on the date noted above.

Witness Signature	Street Address
Witness (Please Print Full Legal Name)	City, County & State of Residence

Telephone Number _____