

Massachusetts Health Care Proxy

1. I, _____ residing at
(Principal, PRINT your name)

(Street)

(City or Town)

(State)

Appoint as my Health Care Agent _____
(Name of person you choose as Agent)

of _____
(Street) (City or Town) (State) (Phone)

(OPTIONAL: If my agent is unwilling or unable to serve, then I appoint as my Alternate:

(Name of person you choose as Agent)

(Street)

(City or Town)

(State)

(Phone)

2. My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations **if any** you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interest. Photocopies of this Health Care Proxy shall have the same force and effect as the original.

3. Signed: _____

Complete only if Principal is physically unable to sign. I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses

(Name)

(Signed)

(City/Town)

(State)

4) **WITNESS STATEMENT:** We the undersigned, each witnessed the signing of the Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health care Agent or Alternate in this document. In our presence this day of _____, _____ 200____

(Signature) Witness #1
Witness #2

(Signature)

Name(print) _____ Name(print) _____

Address: _____ Address: _____

5) **Statements of Health Care Agent and Alternate (OPTIONAL)**

Health Care Agent: I have been named by the Principal as the Principal's Health Care Agent by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldier's Home or other health facility where the principal is presently a patient or resident or has applied for admission. Or if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature) of Health Care Agent)

Alternate: I have been named by the Principal as the Principal's Alternate by this Health care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldier's Home or other health facility where the principal is presently a patient or resident or has applied for admission. Or if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature) of
Alternate)