Health Care Proxy

I, (Name) _____,

residing at (Address) _____

on (Date) _____, hereby create a Health Care Proxy and designate

Name _____ Address _____

Telephone _____ _____

_____

to be my health care agent for making any and all health care decisions on my behalf should I ever become incapacitated. If my agent is ever unable or unwilling to act as my agent, I hereby designate

Name _____ Address _____

Telephone _____ _____

_____

to be my alternative health care agent.

Signature _____ Date _____

My health care agent has the authority to make any and all medical decisions on my behalf should I ever be unable to do so for myself. I have discussed my wishes with my agent (and with my alternative agent) who shall base all decisions on my previous instructions. If I have not expressed a wish with respect to some future medical decision, my agent shall act in a manner that he/she deems to be in my best interests in accord with what he/she knows of my beliefs.

My agent has the further authority to request and receive all information regarding my medical condition and, when necessary, to execute any documents necessary for release of such information. My agent may execute any document of consent or refusal to permit treatment in accord with my intentions. My agent may also admit me to a licensed health care agency or facility as he/she deems appropriate and sign on my behalf any waiver or release from liability required by a physician or a hospital.

As a member of the Catholic Church, I believe in a God who is merciful and in Jesus Christ who is the Savior of the World. As the Giver of Life, God has sent us His only-begotten Son as Redeemer so that in union with Him we might have eternal life. Through His death and resurrection, Jesus has conquered sin so that death has lost its sting (1 Cor. 15:55). I wish to follow the moral teachings of the Catholic Church and to receive all the obligatory care that my faith teaches we have a duty to accept. However, I also know that death need not be resisted by any and every means and that I have the right to refuse medical treatment that is excessively burdensome or would only add to my suffering as I face inevitable death. I also know that I may morally receive medication necessary to relieve my pain even if it is foreseen that its use may have the unintended result of shortening my life.

Witness _____ Date _____

I affirm that the principal is at least eighteen years of age, of sound mind, and under no undue influence.

Witness _____ Date _____

I affirm that the principal is at least eighteen years of age, of sound mind, and under no undue influence.

When initialed here _____, the Advance Medical Directive on the reverse shall be considered an extension of this document. The Advance Medical Directive on the reverse may also be completed independently of this Health Care Proxy.