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HOSPICE AND
PALLIATIVE CARE

MJHS®

# Health Care Proxy

*for*

Name

# Health Care Proxy

I, _____, of

_____

Street/City/State

_____

Daytime Phone Evening Phone

hereby appoint _____, of

_____

Street/City/State

_____

Daytime Phone Evening Phone

as my health care agent to make all health care decisions for me, including artificial nutrition and hydration, If I become unable to decide for myself.

_____

Signature (Principal) Date

This proxy was signed in my presence. The signer is known to me and appears to be of sound mind and able to act of his/her own free will

_____

Witness Date

_____

Witness Date