INDIANA APPOINTMENT OF A HEALTH CARE REPRESENTATIVE

I, ____, of
(Name)

____,
(Address)

hereby voluntarily appoint ____, of
(Name of Health Care Representative)
____

____
______________________________(Address & Telephone Number)

as my health care representative.

In the event that the person I appoint above as health care representative is unable, unwilling or unavailable to serve, I hereby

appoint ____
(Name of Successor Health Care Representative)

of ____
(Address & Telephone Number)

as my substitute representative hereunder.

I authorize my health care representative to make decisions in my best interest concerning my health care including the consent to health care, as well as the withdrawal or withholding of health care. I understand health care to include medical care, treatment, service, or procedure to maintain, diagnose, treat or provide for my physical or mental well-being. Pursuant to the Indiana Health Care Consent Act, I authorize my health care representative to make decisions to withhold or withdraw artificial nutrition and hydration to the extent it is in my best interest to do so. 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would be excessively burdensome, my health care representative may express my will that such health care be withheld or withdrawn and consent on my behalf that any and all health care be discontinued or not instituted, even if death may result.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 or physicians 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 that they are available.

This appointment becomes effective and remains effective if I am incapable of consenting to my health care.
I DO, DO NOT (**circle one**) authorize my health care representative hereby appointed to delegate decision making power to another.

APPOINTER SIGNATURE

I, ____, the Appointer, sign my name to this instrument this __________ day of
____ (day)

____________________________________, ___________, and do hereby declare the undersigned witness that I sign it
(month) (year)

willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am eighteen (18) years of age or older, of sound mind, and under no constraint or undue influence.

____________________________________ ____________________
(Signature) (Date)

____
(Printed Name)

____________________________________ ____________________
(Address) (County)

____
(City/State/Zip)

WITNESS SIGNATURE

I declare that the Appointer who signed this document appears to be of sound mind and acting of his/her own free will. He/She signed (or asked another to sign for him/her) this document in my presence.

I further declare that I am an adult at least eighteen (18) years of age, and I am not the Representative or Successor Representative appointed in this document.

____
(Signature of Witness)

____
(Printed Name)

____
(Witness Address)

____
(City/State/Zip)

____
(Telephone Number)

Compliments of:

King's Daughters' Hospital & Health Services

P.O. Box 447, One King's Daughters' Drive
Madison, Indiana 47250