

INSTRUCTIONS

NEW YORK HEALTH CARE PROXY

PRINT YOUR
NAME

(1) I, _____, hereby appoint:
(name)

PRINT NAME,
HOME ADDRESS
AND
TELEPHONE
NUMBER OF
YOUR AGENT

(name, home address and telephone number of agent)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. **My agent does know my wishes regarding artificial nutrition and hydration.**

This Health Care Proxy shall take effect in the event I become unable to make my own health care decisions.

ADD PERSONAL
INSTRUCTIONS
(If Any)

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows.

PRINT NAME,
AND
TELEPHONE
NUMBER OF
YOUR
ALTERNATE
AGENT

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

(name, home address and telephone number of alternate agent)

ORGAN
DONATION
(OPTIONAL)

(4) Donation of Organs at
Death:

Upon my
death:

I **do not** wish to donate my organs, tissues or parts.

I **do** wish to be an organ donor and upon my death I wish to donate:

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(Continued)

