

MASSACHUSETTS HEALTH CARE PROXY

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

 (Street) (City/town) (State/ZIP)

appoint as my **Health Care Agent**: _____
 (Name of person you choose as Agent)

of _____
 (Street) (City/town) (State/ZIP)

Agent's tel (h) _____ (w) _____ E-mail _____

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

 (Name of person you choose as Alternate Agent)

of _____
 (Street) (City/town) (State/ZIP) (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 to 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 interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

3 **Signed:** _____ **Date:** _____ (mo/day/yr)

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) (Street)

 (City/town) (State/ZIP)

4 **WITNESS STATEMENT:** We, the undersigned, each witnessed the signing of this 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 Agent in this document.

In our presence, on this day _____ (mo / day / yr).

Witness #1 _____ (Signature) Witness #2 _____ (Signature)

Name (print) _____ Name (print) _____

Address _____ Address _____

_____, _____, _____

Statements of Health Care Agent and Alternate Agent (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, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But 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 Agent: I have been named by the Principal as the Principal's **Alternate 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, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But 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 Agent**) _____

* * * * *

**Health Care Proxy developed by Massachusetts Health Decisions in association with
the following member organizations of the Massachusetts Health Care Proxy Task Force:**

Boston University Schools of Medicine and Public Health:	Massachusetts Hospital Association
Law, Medicine, and Ethics Program	Massachusetts Medical Society
Deaconess ElderCare Program	Massachusetts Nurses Association
Hospice Federation of Massachusetts	Medical Center of Central Massachusetts
Massachusetts Bar Association	Suffolk University Law School:
Massachusetts Department of Public Health	Elder Law Clinic
Massachusetts Executive Office of Elder Affairs	University of Massachusetts at Boston:
Massachusetts Federation of Nursing Homes	The Gerontology Institute
Massachusetts Health Decisions	Visiting Nurse Associations of Massachusetts

Additional information and resources for individuals, organizations and professionals available
at <https://masshealthdecisions.org>. Or email: proxy@masshealthdecisions.org