New York Health Care Proxy

(1) I,, hereby appoint:
Agent's Name:
Agent's Home Address:
Agent's Telephone Numbers:
as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.
This proxy shall take effect only when and if I become unable to make my own health care decisions.
(2) Optional: Alternate If the person I appoint is unable, unwilling or unavailable to act as my
health care agent, I hereby appoint:
Alternate's Name:
Alternate's Home Address:
Alternate's Telephone Numbers:
(3) Unless I revoke it, this proxy shall remain in effect indefinitely or until the date or condition I have stated below. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy will expire (specify date or conditions):
(4) Optional Instructions: I direct my agent to make health decisions in accordance with my wishes and limitations as stated below, or as he or she otherwise knows. (attach additional pages as necessary)
My agent knows my wishes regarding artificial nutrition and hydration.

(5) Your Identification (please print)	
Your Name:	
Your Signature:	Date:
Your Address:	
(6) Optional: Organ and/or Tissue Donation Upon my death, I wish to donate my organized (check any that apply and note limitation)	gans, tissues or body parts:
Any needed organs and/or tissues	
Only the following organs and/or tissu	ies:
My donation is for the following:	
transplanttherapyresearch	_educationany use
Your Signature:	Date:
(7) Statement by Witnesses (Witnesses mus cannot be the health care agent or alter	
I declare that the person who signed this do appears to execute this proxy willingly and He or she signed (or asked another to sign to in my presence.	of his or her own free will.
Name of Witness 1 (please print):	Date:
Signature:	
Address:	
Name of Witness 2 (please print):	Date:
Signature:	
Address:	