MASSACHUSETTS HEALTH CARE PROXY

1. I, ____, residing at ________
(print your name here)

____
(street) (city) (state)

appoint as my Health Care Agent ____
(name of person you choose as Agent)

of ____
(street) (city) (state)

_______________________.
(phone)

(Optional: If my Agent is unwilling or unable to serve, then I appoint as my Alternate:

____
(name of person you choose as Alternate)

of ____
(street) (city) (state)

_______________________.
(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 of your AGENT's authority):

____

____

I direct my Agent to make health care decisions based on his/her assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on his/her assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original.

NOTE: You should not choose as your health care agent an employee or member of the health care facility in which you are now or expect to be a patient, unless you are related to that person by blood, marriage, or adoption.

Signed: ____ Date ________

3. 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) (state)

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 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 in this document.

In our presence this _________day of _________________________, in the year _________

Witness #1 ____
Name (print) ____
Address ____
____

Witness #2 ____
Name (print) ____
Address ____
____