LINCOLN HILL MANOR

53 Lincoln Street Spencer MA 01562
(508) 885-3338

Health Care Proxy

I, _____, residing at Lincoln Hill Manor Rest Home appoint as my
(Principal: PRINT your name)
Health Care Agent:

_____ _____
Agent Name *Agent Telephone*

_____
(Street) (City/Town) (State/ZIP)
Agent Address

Optional If my agent is unwilling or unable to serve, then I appoint as my Alternate with all the same powers:

_____ _____
Agent Name *Agent Telephone*

_____
(Street) (City/Town) (State/ZIP)
Agent Address

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.

Signed _____ Date _____/_____/_____

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 _____/_____/_____.

Witness #1 _____ Witness #2 _____
(Signature) (Signature)
Name _____ Name _____
(Print name) (Print name)
Address_____ Address_____

_____ _____