Deaconess

INDIANA HEALTH CARE REPRESENTATIVE:

I, _____, being at least eighteen (18) years old and of sound mind, give my Health Care Representative named below permission to make health care decisions for me, including end-of- life decisions, if I am unable to make decisions for myself. My Health Care Representative must try to discuss decisions with me. However, if I am not able to communicate, they may make such decisions for me, after consulting with my physicians and providers, including other relevant family members. My Health Care Representative must act in good faith and make decisions in my best interests. If my Health Care Representative is unavailable or unwilling to serve, the alternate Health Care Representative named below will take their place.

My Health Care Representative (HCR):

_____
Name of HCR Appointed

_____
Telephone Number of HCR

My Alternate Health Care Representative (HCR):

_____
Name of Alternate HCR Appointed

_____
Telephone Number of Alternate HCR

REQUIRED SIGNATURES:
By signing this document, I cancel and revoke every health care power of attorney I signed in the past.

_____ _____ _____
Signature (Declarant) Date Printed Name (Declarant)

This form must be either signed by 2 adult witnesses (below left) or notarized (below right) to be legally valid.

SIGNATURE OF 2 ADULT WITNESSES

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

_____
Signature of Adult Witness 1

_____ _____
Printed Name of Adult Witness 1 Date

_____
Signature of Adult Witness 2

_____ _____
Printed Name of Adult Witness 2 Date

_____ Initial here if the Witnesses participated by phone.

NOTARIZATION

STATE OF INDIANA)
) SS:
COUNTY OF _____)

Before me, a Notary Public, personally appeared _____ [*name of signing Declarant*], who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this _____ day of _____, 20____.

_____
Signature of Notary Public

_____
Notary's Printed Name *(if not on seal)*

_____
Commission Number *(if not on seal)*

_____
Commission Expires *(if not on seal)*

_____
Notary's County of Residence