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# HEALTH CARE PROXY

**1). I,**_____ Hereby appoint_____
Name:_____ Home Address:_____
Tel/Cel:_____ 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 Agent**

Si la persona que designo no se encuentra disponible, no quiere hacerlo o no puede actuar como mi agente médica,

Hereby appoint_____ Name:_____
Home Address:_____ _____
Tel/Cel:_____
as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

**3).** Unless I revoke it or state an expiration date or circumstance under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here). This proxy shall expire (specify date or conditions):_____
_____

**4). Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may stateyour wishes or your limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

_____
_____

In order for your agent to make health care decisions for you about artificial nutrition or hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

**5). Your identification (please print)**

Your Name:_____ Signature:_____

Home Address:_____ _____

Date:_____

**6). Optional: Organ and/or Tissue Donation**

I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

- ☐ Any needed organs and/or tissues
- ☐ The following organs and/or tissues_____ _____
- ☐ Limitations_____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by the law, to consent to a donation on your behalf.

Your Signature_____ Date_____

**7). Statement by Witnesses** (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)
I declare that the person who signed this document is personally known to me and appears to be of sound mind and is acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date_____ Date_____

Name of Witness 1 (print)_____ Name of Witness 2 (print)_____

Signature_____ Signature_____

Address_____ Address_____

NEW YORK STATE DEPARTMENT OF HEALTH

# Nonhospital Order Not to Resuscitate (DNR Order)

Person's Name: _____

Date of Birth: _____

## Do not resuscitate the person named above.

*Physician's or Nurse Practitioner's Signature: _____

Print Name: _____

License Number: _____

Date: _____

It is the responsibility of the physician or nurse practitioner to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

*For individuals with an Intellectual or Developmental Disability (I/DD), the non-hospital DNR **must** be signed by a physician.

For individuals with an I/DD who do not have capacity and do not have a health care proxy, the physician must ensure compliance with SCPA Section 1750-b.