Healthcare Power of Attorney

Name: ___________________________________

Date of Birth: _____/_____/_____

I designate the following as my agent to make health care decisions for me in the event I am unable to or choose not to make these decisions for myself.

The person I choose as my Healthcare Agent is:

Name	Phone
Address	City/State/Zip

If this person is not able or willing to make my healthcare decisions, then the following people are my next choices:

Second Choice Name	Phone
Address	City/State/Zip
Third Choice Name	Phone
Address	City/State/Zip

This Power of Attorney for Health Care shall not be affected by any subsequent disability or incapacity or other condition that makes an express revocation of my agent impossible or impractical. I also grant my agent the authority to qualify me for all government entitlements including, but not limited to, Medicaid, Medicare, and Supplemental Social Security.

Signature	Date

Witnesses (must be 18 years of age or older and not related by blood or marriage or stand to gain financially in the event of your death.)

Witness 1 Signature	Witness 1 Print Name

Witness 2 Signature

Witness 2 Print Name