Banyan Community Health Center, Inc.

Designation of Healthcare Surrogate

In the event that my physician determines that I am incompetent or so incapacitated as to provide expressed and informed consent for medical treatment, surgical intervention or diagnosis procedures, I, _____, wish to designate the following person(s) to
Last name, First name, Middle Initial
make those decisions for me:

DESIGNEE

Name: _____ Relationship (if any) _____

Address: _____ Telephone: _____

ALTERNATIVE DESIGNEE

If any person that I have named is unable to act on my behalf, I authorize the following person to act on my behalf.

Name: _____ Relationship (if any) _____

Address: _____ Telephone: _____

I fully understand that this document will permit the above identified designee to support, withhold, or withdraw consent for intended treatment and to do so on my behalf. That individual may also apply for public benefits to defer the cost of healthcare and authorize for my transfer to or from a healthcare facility.

I further reaffirm that this designation is not being made as a condition of treatment or admission to a healthcare facility. I understand should my judgmental incapacitation or incompetence be reversed such as that I am once again considered competent to make my own decisions, such decisions will once again be mine.

I understand that I may rescind this declaration at any time so long as I am judged to be competent and capable to make such judgments.

Additional Instructions: _____
_____
_____

Do you have a Living Will Declaration? ☐ Yes ☐ No
Signature: _____ Date: _____
Witness #1: _____ Date: _____
Witness #2: _____ Date: _____

Note: One witness should not be a spouse, blood relative, heir to the estate of the designee, or responsible for paying healthcare costs for the individual.