DESIGNATION OF MEDICAL SURROGACY

In the event that I (Printed Name of Grantor) _____ become ill or injured and my decisional capacity is impaired, I hereby designate the following individual as my ***medical surrogate*** to act on my behalf to make health care decisions for me:

_____
Name

_____
Telephone (home) (cell) (work) (e-mail)

_____
Address Relationship to undersigned

If the above-named individual refuses or is not able to act for me, I designate the following as my ***medical surrogate*** to act on my behalf to make health care decisions for me:

_____
Name

_____
Telephone (home) (cell) (work) (e-mail)

_____
Address Relationship to undersigned

In the event that the above-named designee(s) cannot be reached, I hereby designate the ***faculty leader*** or his/her/their representative to act on my behalf in an emergency should my decisional capacity be impaired. Any prior designation is revoked.

THIS DOCUMENT MUST BE NOTARIZED BEFORE IT IS SUBMITTED.

I have read, understand and confirm that all of the information provided is accurate and complete.

Participant's Signature_____Date_____

Printed Participant's Name_____

Before me, the undersigned authority came; the Grantor, who is eighteen (18) years of age or older, acknowledged that he/she voluntarily dated and signed this writing, or directed it to be signed and dated as above. Done this _____ day of _____, 20_____.

State of _____

County of_____

NOTARY PUBLIC_____

My Commission Expires: _____