New York State Health Care Proxy

(1) **I**, _____, hereby appoint _____
_____
[agent's name, address, telephone number], 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 Instructions**. I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows.
My agent and my substitute agent are aware of my wishes regarding artificial nutrition and hydration and I authorize my agent and my substitute agent to make decisions in that regard. (Unless your agent knows your wishes about artificial nutrition and hydration tubes, your agent will not be allowed to make decisions about artificial nutrition and hydration).

(3) **Name of Substitute Agent**: I hereby appoint as my health care agent, if the person I appointed above is unable, unwilling or unavailable to act: _____
_____
_____.

(4) Unless I revoke it, this proxy shall remain in effect indefinitely.

(5) Your Signature _____

Date _____

Address _____

(6) **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 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.

Witness 1	_____	Witness 2	_____
Signature	_____	Signature	_____
Date	_____	Date	_____
Address	_____	Address	_____
	_____		_____