

HEALTH CARE PROXY/LIVING WILL

FIRST. I (name) _____ hereby appoint
(name) _____
(address) _____

as my agent to make any and all health care decisions for me in accordance with my wishes and the limitations stated below.

SECOND. If I become terminally ill; in a coma or unconscious, with no hope of recovery or if I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do not want (initial items you do not want)

_____ artificial respiration	_____ antibiotics
_____ artificial nutrition/hydration	_____ psychosurgery
_____ cardiopulmonary resuscitation	_____ dialysis
_____ antipsychotic medication	_____ transplantation
_____ electric shock therapy	_____ blood transfusions

THIRD. I wish to live out my last days at home rather than in a hospital if it does not jeopardize the chance of my recovery to a meaningful and conscious life and does not impose an undue burden on my family.

FOURTH. If any of my tissues or organs are sound and would be of value as transplants to other people, I freely give my permission for such donation.

FIFTH. It is my desire (initial and complete as necessary)

_____ that this proxy/living will remain in effect indefinitely

_____ that this proxy/living will shall terminate _____

I sign and declare this as my Health Care Proxy/Living Will in the presence of the persons witnessing it at my request this _____ day of _____ 200 .

Witnesses (sign) _____ (sign) _____

(print name) _____ (print name) _____

(address) _____ (address) _____

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