

DWIGHT LEWIS, M.D.

Health Care Proxy

(1) I _____ hereby
appoint (name, home address, and telephone number)

as my health care agent to make any and all health care decisions for me, including decisions about artificial nutrition and hydration (feeding tubes), except to the extent that I state otherwise. This proxy shall take effect 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. (Write on back if necessary.)

(Unless your agent knows your wishes about artificial nutrition and hydration, your agent will not be allowed to make decisions about artificial nutrition and hydration.)

(3) Name of Substitute or fill-in agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent. (Name, home address, and telephone number).

(4) Unless I revoke it, this proxy shall remain effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

Signature_____

Address_____

Date_____

Statement by Witness (Must be 18 or Older):

I declare that the person who signed this document is personally known to me or appears to be of sound mind and acting of his or her free will. He or she signed (or asked another of him or her) this document in my presence.

Witness 1_____

Address_____

Witness 2_____

Address_____