

INSTRUCTIONS

**NEW YORK
HEALTH CARE PROXY**

**PRINT YOUR
NAME**

(1) I, _____, hereby appoint:
(name)

**PRINT NAME,
HOME ADDRESS
AND
TELEPHONE
NUMBER OF
YOUR AGENT**

(name, home address and telephone number of agent)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. My agent does know my wishes regarding artificial nutrition and hydration.

This Health Care Proxy shall take effect in the event I become unable to make my own health care decisions.

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

(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.

**PRINT NAME,
HOME ADDRESS
AND
TELEPHONE
NUMBER OF
YOUR
ALTERNATE
AGENT**

(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 of alternate agent)

**ORGAN
DONATION
(OPTIONAL)**

(4) Donation of Organs at Death: Upon my death:

[] I **do not** wish to donate my organs, tissues or parts.

[] I **do** wish to be an organ donor and upon my death I wish to donate:

**ORGAN
DONATION
(OPTIONAL)
CONTINUED**

(a) Any needed organs, tissues, or parts;

OR

(b) The following organs, tissues, or parts

(c) My gift is for the following purposes:

(put a line through any of the following you do not want)

- (i) Transplant
- (ii) Therapy
- (iii) Research
- (iv) Education

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

**ENTER A
DURATION OR A
CONDITION
(IF ANY)**

**SIGN AND DATE
THE DOCUMENT
AND PRINT
YOUR ADDRESS**

(6) Signature _____ Date _____

Address _____

**WITNESSING
PROCEDURE**

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as proxy by this document.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

**YOUR
WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES**

INSTRUCTIONS

NEW YORK LIVING WILL

This Living Will has been prepared to conform to the law in the State of New York, as set forth in the case In re Westchester County Medical Center, 72 N.Y.2d 517 (1988). In that case the Court established the need for "clear and convincing" evidence of a patient's wishes and stated that the "ideal situation is one in which the patient's wishes were expressed in some form of writing, perhaps a 'living will.'"

**PRINT YOUR
NAME**

I, _____, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in an **incurable or irreversible mental or physical condition with no reasonable expectation of recovery**, including but not limited to: (a) **a terminal condition**; (b) **a permanently unconscious condition**; or (c) **a minimally conscious condition in which I am permanently unable to make decisions or express my wishes**.

I direct that my treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

While I understand that I am not legally required to be specific about future treatments **if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:**

- I do not want cardiac resuscitation.
- I do not want mechanical respiration.
- I do not want artificial nutrition and hydration.
- I do not want antibiotics.

However, I **do want** maximum pain relief, even if it may hasten my death.

**CROSS OUT
ANY
STATEMENTS
THAT DO NOT
REFLECT YOUR
WISHES**

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

Other directions:

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed _____ Date _____

Address _____

**SIGN AND DATE
THE DOCUMENT
AND PRINT YOUR
ADDRESS**

**WITNESSING
PROCEDURE**

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

**YOUR
WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES**