



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 *program director(s)* 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 TO TnCIS

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, and 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: _____