APPENDIX Q
Designation of Medical Surrogacy

Fill this form out in ink.

In the event that I _____ become ill or injured and my
(*Printed Name of Traveler*)
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 *(street)* *(city)* *(state)* *(zip code)* 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 *(street)* *(city)* *(state)* *(zip code)* 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(s) to act on my behalf in an emergency should my decisional capacity be impaired.

Any prior designation is revoked.

Do not sign this form until in the presence of a Notary

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:_____