



APPENDIX Q  
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(s) 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: \_\_\_\_\_