FORM FOR APPOINTING HEALTH CARE REPRESENTATIVE AND ALTERNATE HEALTH CARE REPRESENTATIVE (STATE OF OREGON)

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a health care representative.

- If you have completed a form appointing a health care representative in the past, this new form will replace any older form.
- You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.
- If you become too sick to speak for yourself and do not have an effective health care representative appointment, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635(2).

1. ABOUT ME.

Name:_____ Date of Birth: _____

Telephone numbers: (Home)_____(Work)_____(Cell) _____

Address: _____

E-mail: _____

2. MY HEALTH CARE REPRESENTATIVE.

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

Name:_____ Relationship: _____

Telephone numbers: (Home)_____(Work)_____(Cell) _____

Address: _____

E-mail: _____

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative's appointment.

First alternate health care representative:

Name:_____ Relationship: _____

Telephone numbers: (Home)_____(Work)_____(Cell) _____

Address: _____

E-mail:_____

Second alternate health care representative:

Name:_____ Relationship: _____

Telephone numbers: (Home)_____(Work)_____(Cell) _____

Address: _____

E-mail: _____

3. MY SIGNATURE.

My signature:_____ Date: _____

4. WITNESS.

COMPLETE EITHER A OR B WHEN YOU SIGN.

A. NOTARY:

State of _____

County of _____

Signed or attested before me on_____, 2_____, by_____.

_____
Notary Public - State of Oregon

B. WITNESS DECLARATION:

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternative health care representative, and I am not the person's attending health care provider.

Witness Name (print): _____

Signature: _____ Date: _____

Witness Name (print): _____

Signature: _____ Date: _____

5. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

First alternate health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

Second alternate health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____