# Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional instuctions: I direct my proxy to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary)

_____

_____

_____

(Unless your agent knows your wishes about artificual nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions on reverse for samples of langiage you could use.)

(3) Name of substitute or fill-in proxy if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____
(name, home address and telephone number)

_____

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

_____

(5) Signature _____

Address _____

Date _____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

# State of New York
# Department of Health

## Nonhospital Order Not to Resuscitate
## (DNR Order)

Person's Name_____

Date of Birth __ / __ / __

Do not resuscitate the person named above.

Physician's Signature_____

Print Name _____

License Number _____

Date __ / __ / __

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

DOH-3474 (04/09)

Society for the
Right to Die

250 West 57th Street/New York, NY 10107

# 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 of In re Westchester County Medical Center, 72 N.Y.2d 517 (1988). In that case the Court approved the use of a Living Will, stating that the "ideal situation is one in which the patient's wishes were expressed in some form of writing, perhaps a 'living will.' "*

**INSTRUCTIONS:**

**This is an important legal document. It sets forth your directions regarding medical treatment. You have the right to refuse treatment you do not want, and you may request the care you do want. You may make changes in any of these directions, or add to them, to conform them to your personal wishes.**

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 serves only to prolong the process of my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery.

These instructions apply if I am a) in a terminal condition; b) permanently unconscious; or c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that 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 tube feeding.
I do not want antibiotics.

I do want maximum pain relief.

Other directions (insert personal instructions):_____

_____

_____

_____

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.

**Sign and date here in the presence of two adult witnesses, who should also sign.**

Signed: _____ Date: _____

Witness: _____

Address: _____

_____

Witness: _____

Address: _____

_____

*Keep the signed original with your personal papers at home. Give copies of the signed original to your doctor, family, lawyer and others who might be involved.*