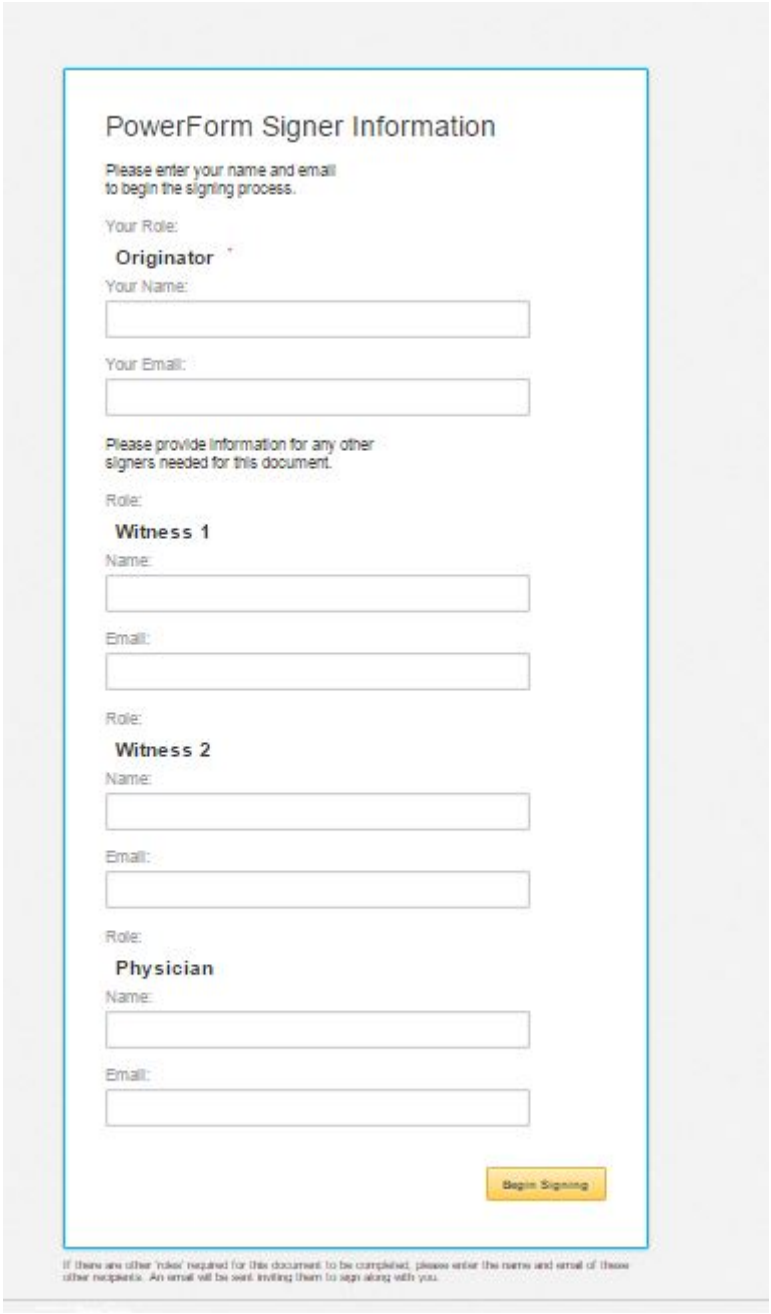
PowerForm Signer Information
Please enter your name and email to begin the signing process.
Your Role:
Originator
Your Name:
Your Email:
Please provide information for any other signers needed for this document.
Role:
Witness 1
Name:
Email:
Role:
Witness 2
Name:
Email:
Role:
Physician
Name:
Email:
Begin Signing
If there are other 'roles' required for this document to be completed, please enter the name and email of these other recipients. An email will be sent inviting them to sign along with you.

MASSACHUSETTS HEALTH CARE PROXY FORM

I, EXAMPLE _____(the principal), residing at_____, _____ County, Massachusetts, pursuant to Massachusetts General Laws Chapter 201D, appoint the following person to be my Health Care Agent:

Name: _____ Phone #: _____

Address:_____ City/State/Zip: _____

If my Health Care Agent named above is not available, I name as an alternate Health Care Agent:

Name: _____ Phone #: _____

Address:_____ City/State/Zip: _____

I give my Health Care Agent authority to make all health care decisions on my behalf if I become incapable of making such decisions for myself, including but not limited to decisions concerning initiation, continuing, withdrawing or refusing any life-prolonging care, treatment, service or procedure, EXCEPT (here list the limitations, IF ANY, you wish to place on your Agent's authority):

_____

_____

_____

_____

_____

My Health Care Agent shall make health care decisions for me in accordance with my Health Care Agent's assessment of my wishes, including my religious and moral beliefs. If my wishes are unknown, my Health Care Agent shall make such decisions for me only in accordance with my Health Care Agent's assessment of my best interests.

My Agent may obtain any and all medical information, including confidential medical information, as I would be entitled to receive. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

My Health Care Agent's authority to act on my behalf shall exist only for the period during which my attending physician determines that I lack capacity to make or communicate health care decisions for myself.

I sign this Health Care Proxy on _____, 20_____ in the presence of two witnesses.

Signed:_____

(If the Principal cannot sign) The principal is unable to sign and at the direction of the principal I have signed his/her name in his/her presence and in the presence of two witnesses.

Name:_____

Street: _____ City/Town: _____

MASSACHUSETTS HEALTH CARE PROXY FORM

We, the undersigned witnesses, each declare in the presence of the principal that neither of us has been named as Health Care Agent or alternate Health Care Agent in this Health Care Proxy, and we further declare that the principal signed this instrument as his/her Health Care Proxy, or directed its execution, in the presence of each of us, that each of us signs this Health Care Proxy as witness in the presence of the principal, and that to the best of our knowledge he/she is eighteen (18) years of age or over, of sound mind, and under no constraint or undue influence.

Witness: _____ Printed Name: _____

Address: _____

Witness: _____ Printed Name: _____

Address: _____

Statement of Health Care Agent (optional)

Health Care Agent: I have been named by _____ (the "principal") as the principal's **Health Care Agent** by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes at a time of possible incapacity, and I will try to give effect to the principal's wishes. I am not an operator, administrator or employee of a hospital, nursing home, rest home, Soldiers Home or other health facility where the principal is presently a patient or resident or has applied for admission; or if I am such a person, I am also related to the principal by blood, marriage or adoption.

Signature of **Health Care Agent:**_____ Date: _____

Statement of Alternate Health Care Agent (optional)

Alternate: I have been named by _____ (the "principal") as the principal's **Alternate Health Care Agent** by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes at a time of possible incapacity, and I will try to give effect to the principal's wishes. I am not an operator, administrator or employee of a hospital, nursing home, rest home, Soldiers Home or other health facility where the principal is presently a patient or resident or has applied for admission; or if I am such a person, I am also related to the principal by blood, marriage or adoption.

Signature of **Alternate Health Care Agent:**_____ Date: _____

A letter to my loved ones...

Dear Loved Ones,

I want the best quality of life possible during my last days. Therefore, I hereby request as follows...

- ☐ (a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.
- ☐ (b) If my temperature is above normal, I want a cool moist cloth put on my head.
- ☐ (c) I want my mouth and lips kept moist.
- ☐ (d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.
- ☐ (e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.
- ☐ (f) I want my personal care such as nail clipping, hair combing, teeth brushing and shaving as long as they do not cause me pain.

I hope my family and friends would consider that...

- [ ] (a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.
- [ ] (b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.
- [ ] (c) Please don't be afraid to hold my hand or hug me.
- [ ] (d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me.
- [ ] (e) Please maintain a cheerful atmosphere around me.
- [ ] (f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.
- [ ] (g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.
- [ ] (h) If at all possible, allow me to die in my home.
- [ ] (i) Please arrange for me to watch television or listen to my favorite sports events.
- [ ] (j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.
- [ ] (k) I want to have my favorite types of music played when possible.
- [ ] (l) I want to have religious readings read to me when I am near death.
- [ ] (m) I want to have my favorite poems read to me from time to time.

I want you to know the following about my thoughts and concerns, if I am disabled and cannot convey these thoughts to you verbally...

(1) I want you to know that I love you. ☐

(2) I would like to be forgiven for the times I have hurt you. ☐

(3) I forgive you for what you may have done to me in my life. ☐

(4) I want you to know that I do not fear death itself. ☐

(5) I want all of my family members to recommit their love for one another. ☐

(6) Please remember me the way I was before I had a terminal illness. ☐

(7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all. ☐

(8) Don't be afraid to seek counseling, if you have trouble with my death. ☐

If friends want to know how I want to be remembered, tell them the following...

_____

_____

_____

_____

The following person(s) know my funeral plans...

_____

_____

_____

At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...

_____

_____

_____

_____

I also have the following requests...

_____

_____

_____

_____

These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Dated this ____ day of _____, 20_____.

Signature _____

Print Name EXAMPLE