



**LONG BEACH MEDICAL CENTER**

## Health Care Proxy

1. I, \_\_\_\_\_ hereby appoint:  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_  
Telephone \_\_\_\_\_  
as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This shall take effect when and if I become unable to make my own health care decisions.
  
2. Optional instructions: I direct my agent 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 artificial nutrition and hydration [feeding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions for samples of language you could use.)
  
3. Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_  
Telephone \_\_\_\_\_
  
4. Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire \_\_\_\_\_  
\_\_\_\_\_
  
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 \_\_\_\_\_