INDIANA
ADVANCE DIRECTIVE

APPOINTMENT OF HEALTH CARE REPRESENTATAIVE:

I, _____, give my HCR named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decisions that I could have made for myself if able. If my HCR is unavailable or unwilling to serve, the backup HCR named below will take their place.

My Health Care Representative (HCR):

_____
Name

_____
Phone Number

My Backup Health Care Representative:

_____
Name

_____
Phone Number

REQUIRED SIGNATURES:
By signing this form, I cancel and revoke every health care power of attorney I signed in the past.

_____ _____ _____
Signature (Declarant) Date Printed Name (Declarant)

This form must be either signed by 2 adult witnesses (below left) or notarized (below right) to be legally valid.

SIGNATURE OF 2 ADULT WITNESSES

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

_____
Signature of Adult Witness 1

_____
Date

_____
Signature of Adult Witness 2

_____
Date

_____ Initial here if the Witnesses participated by phone.

This advance directive was created by the Indiana Patient Preferences Coalition and is freely available. See www.INadvancedirectives.org for more information.

NOTARIZATION

STATE OF INDIANA)
) SS:
COUNTY OF _____)

Before me, a Notary Public, personally appeared _____ [*name of signing Declarant*], who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this _____ day of _____, 20____.

_____
Signature of Notary Public

_____
Commission Expires *(if not on seal)*

_____
Notary's County of Residence