APPOINTMENT OF HEALTH CARE REPRESENTATIVE:

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):

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

My Backup Health Care Representative:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

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.

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