Designation of Medical Surrogacy

In the event that I (Printed Name of Traveler) _____become ill or injured and my decisional capacity is impaired, I hereby designate the following individual as my medical surrogate to act on my behalf to make health care decisions for me:

_____

Name

_____

Telephone (home) (cell) (work) (e-mail)

_____

Relationship to undersigned

If the above-named individual refuses or is not able to act for me, I designate the following as my medical surrogate to act on my behalf to make health care decisions for me:

_____

Name

_____

Telephone (home) (cell) (work) (e-mail)

_____

Relationship to undersigned

In the event that the above-named designee(s) cannot be reached, I hereby designate the Program Director(s) or his/her/their representative(s) to act on my behalf in an emergency should my decisional capacity be impaired. Any prior designation is revoked.

THIS DOCUMENT MUST BE NOTARIZED
I have read, understand and confirm that all of the information provided is accurate and complete.

Participant's Signature_____ Date_____

Printed Participant's
Name_____

Before me, the undersigned authority come the Grantor, who is eighteen (18) years of age or older and acknowledged that he/she voluntarily dated and signed this writing, or directed it to be signed and dated as above.

Done this ____ day of _____, 20___.

State of _____

County of_____

NOTARY PUBLIC_____

My Commission Expires: _____