NEW ENGLAND
Cancer Specialists

Health Care Agent Form

MY INFORMATION

My First Name | Middle | Last | DOB

Address | City | State | Zip

MY HEALTH CARE AGENT

This is the person I want to make health-related decisions for me if I am unable.

Agent's Name | Relationship to Me | Phone Number(s)

Address | City | State | Zip

SECOND-CHOICE HEALTH CARE AGENT (OPTIONAL)

This is the person I want to make health-related decisions for me if my health care agent is not willing, reasonably available, or able to make decisions for me.

Agent's Name | Relationship to Me | Phone Number(s)

Address | City | State | Zip

SIGNING THE FORM

My Signature | Printed Name | Date Signed

Two adult witnesses must sign and date this form after watching you sign.
Your agent does not sign this form and cannot sign as a witness.

Signature of First Witness | Printed Name | Date Signed

Address of First Witness | City | State | Zip

Signature of Second Witness | Printed Name | Date Signed

Address of Second Witness | City | State | Zip