BORINQUEN MEDICAL CENTERS

Advance Directives

DESIGNATION OF HEALTH CARE SURROGATE

Name: _____ MR#_____
(Last) (First) (M.I.)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____
(Last) (First) (M.I.)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: (_____) _____-_____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: _____
(Last) (First) (M.I.)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: (_____) _____-_____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

Signed: _____

Date: _____-_____-_____

Witnesses: 1. _____
2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.