APPOINTMENT OF HEALTH CARE AGENT FOR _____
(TENNESSEE) ***(print or type name of patient)***

If I become unable to make or communicate decisions for myself, it is up to my Health Care Agent to communicate my health care wishes and to see that my legal rights are protected. While there may be others who wish to be involved in my care, I want my Agent to have the final say on any & all health care decisions, including:

- Decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my condition;
- Decisions to provide, withhold or withdraw life-sustaining treatments, including artificially provided nutrition and hydration, &;
- Decisions regarding organ donation, burial arrangements, cremation, and autopsy.

I remind my Agent of the responsibility to honor any other advance directives that I've completed and to follow any additional instructions I have left. If my Primary Agent is either unavailable or unwilling to serve, I would like my Alternate Agent named below to make these health care decisions for me. (Note: you do not have to name an Alternate Agent.)

NOTE: If there are any decisions that you do **not** want your Health Care Agent to make for you, or if you have any additional instructions for your Health Care Agent, please list them on the back of this form.
☐ Check here if you have added additional instructions.

Primary Agent:

_____
Name (print)

_____
Address

_____
City State Zip Code

(_____) _____
Area Code Home Phone Number

(_____) _____
Area Code Work/Cell Phone Number

_____ _____/_____
Patient's name (please print or type) **Date**

Alternate Agent (optional):

_____
Name (print)

_____
Address

_____
City State Zip Code

(_____) _____
Area Code Home Phone Number

(_____) _____
Area Code Work/Cell Phone Number

_____ _____/_____
Signature of patient *(must be at least 18 or emancipated minor)* **Date**

To be legally valid, you must complete either Block A or Block B below

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Block A Witnesses (TWO witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form. Signature of witness number 1 **Date**

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his/her death. I witnessed the patient signature on this form. Signature of witness number 2 **Date**

Block B Notarization

STATE OF TENNESSEE COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____
Signature of Notary Public