HALLMARK HEALTH SYSTEM

MASSACHUSETTS HEALTH CARE PROXY

I,_____**, born on**_____**and residing at**_____

(Principal – Print Your Name) (DD/MM/YYYY) (Street) (City, State, Zip)

Appoint as my Health Care Agent_____

(Name of person you name as agent)

_____ of_____ _____

(Street) (City, State, Zip) (Telephone number)

Appoint as my Alternate Health Care Agent_____

(Name of person you name as agent)

_____ of_____ _____

(Street) (City, State, Zip) (Telephone number)

My Health Care Agent shall have the authority to make any and all health care decisions on my behalf including decisions about life-sustaining treatment, subject to any limitations as stated below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, if any, you wish to place on your Agent's authority):

I direct my Health Care Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

Signed:_____

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

_____

(Name) (Address)

WITNESS STATEMENT: We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Agent or in this document. Both of us have witnessed the signature by the person who signed this Health Care Proxy, or witnessed it signed at the person's direction, in our presence of each other this:

_____ day of _____, _____

Witness #1_____ Witness #2_____

(Signature) (Signature)

Name (print)_____ Name (print)_____

Address_____ Address:_____

_____ _____