

**AFFIDAVIT OF SURROGATE HEALTH CARE DECISION MAKER**

**THE UNDERSIGNED HEREBY CERTIFIES THAT:**

1. The undersigned is the \_\_\_\_\_ of  
(nature of relationship)  
\_\_\_\_\_, a patient at \_\_\_\_\_  
(patient full name) (name of facility)  
("the Patient") and desires to act as a surrogate health care decision maker for the Patient.

2. To the best of the knowledge and belief of the undersigned, there is no legal guardian, spouse, adult child, parent, adult sibling, or adult grandchild of the Patient available to act as a surrogate health care decision maker.

3. Set forth below is a statement of the undersigned's prior relationship with the Patient and specific facts demonstrating regular contact with the Patient sufficient to make the undersigned familiar with the patient's activities, health and personal beliefs:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. The undersigned has read the foregoing matter and does hereby swear and affirm under penalty of perjury that the representations herein are true, and the facts sworn to by the undersigned represent matters to which he is competent and qualified to testify.

**IN WITNESS WHEREOF**, the undersigned has executed this Affidavit of Surrogate Health Care Decision Maker this \_\_\_\_\_ day of \_\_\_\_\_

**WITNESS:**

\_\_\_\_\_

\_\_\_\_\_  
( name of decision maker)

\_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_