If label not available, please fill in below:
NAME:)_____
DOB:_____
MRN:_____

HEALTHCARE REPRESENTATIVE DECLARATION

I,_____ have authority
(Name of Health Care Representative)

to serve as the health care representative for _____,
(Name of Patient)

date of birth, _____/_____/_____,with whom I/we have the following relationship:

(Initials)

_____ Spouse (and there are no adult children with a person other than the spouse)
_____ Spouse and adult child(ren) of person other than the spouse
_____ Adult child(ren)
_____ Parent(s)
_____ Adult sibling(s)
_____ Adult grandchild(ren)
_____ Other_____

I/we certify that there are no persons in a higher class (as designated above) who are available and willing to serve as the health care representative.

I/we certify that there either are no other members of the same class or that any other members of the same class do not wish to act as health care representatives.

If more than one person is acting as the health care representative:

I/we certify that there are no other persons (as designated above) who are available and willing to serve as the health care representative.

We,_____and
(Name of Health Care Representative)

_____ certify we both
(Name of Health Care Representative)

understand that healthcare decisions can be made by a simple majority of the healthcare representatives and that if the healthcare representatives are equally divided on a decision, then the healthcare provider will wait until a majority agrees on a decision. I/we hereby state that the facts set forth are true and correct to the best of my/our knowledge, information, and belief. I/we understand that the statements made herein are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities).

_____ _____
Signature of Health Care Representative Date

_____ _____
Signature of 2nd Health Care Representative (if applicable) Date

**********Office Use Only**********

Received by:_____ Date:_____ Site:_____

Completed by:_____ Date:_____