My Health Care Proxy Information

My Name: _____

Address: _____

Phone: _____

Where my health care proxy form is located:

☐ I have completed a **personal wishes statement**

☐ I have a **comfort care/ do not resuscitate order**

See other side for contact information

Central Massachusetts Partnership to Improve Care at the End of Life, Inc.
www.betterending.org

Alternate Name: _____

Number: _____

Health Care Agent: _____

Number: _____

I have talked with my family and my doctor about the care I want.
If I am unable to speak for myself, please contact: