Health Care Proxy

(1) **I,** R. Ernest Mahaffey

hereby appoint Barbara Craig

(name, home address and telephone number)

1581 Twin Palms Loop, Lutz, Florida (813) 695-1297

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as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) **Optional: Alternate Agent**

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint:

Lane Mahaffey, 3635 Berger Rd., Tampa, Florida (813) 817-0384

(name, home address and telephone number)

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as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*:

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(4) **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*:

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

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(5) Your Identification *(please print)*

Your Name: R. Ernest Mahaffey

Your Signature _____ Date 6/21, 2023

Your Address: 27 South Terrace, Chautaugua, New York 14722

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☒ Any needed organs and/or tissues

☐ The following organs and/or tissues

_____

☐ Limitations

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or

prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date 6/21/23, 2023

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date 6/21/2023 Date 6/21/23

Name of Witness 1
(print) DAVID W. EARNEST

Signature _____

Address Chicago, IL 60602

Name of Witness 2
(print) DAVID STERNBERG

Signature _____

Address Buffalo, New York 14209

NEW YORK STATE
Department of Health

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