





If my agent is not available, I designate the following person as my alternative agent:

\_\_\_\_\_  
Name of Alternative Agent (Spouse, adult child, friend, or other trusted person)

\_\_\_\_\_  
Name of Agent (Spouse, adult child, friend, or trusted person) Relationship

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Home Phone Work Phone E-Mail

\_\_\_\_ My agent may make all health-care decisions for me.

**OR**

\_\_\_\_ My agent may make all health-care decisions for me except: \_\_\_\_\_

\_\_\_\_ My agent's authority to make health-care decisions for me takes effect immediately.

**OR**

\_\_\_\_ My agent's authority becomes effective when my primary physician determines that I am unable to make health-care decisions.

**Important: Witnesses** cannot be your health-care agent, a health-care provider, or an employee of a health-care facility. One witness cannot be a relative or have inheritance rights.

\_\_\_\_\_  
Print Your Name Your Signature Date

OPTION 1: WITNESSES

\_\_\_\_\_  
Witness #1 Print Name Witness Signature Date

\_\_\_\_\_  
Street Address City State Zip Code

\_\_\_\_\_  
Witness #2 Print Name Witness Signature Date

\_\_\_\_\_  
Street Address City State Zip Code

OPTION 2: NOTARY PUBLIC

State of Hawai'i, \_\_\_\_\_ (County)

On this \_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_, before me, \_\_\_\_\_

\_\_\_\_\_, (insert name of notary public ) appeared \_\_\_\_\_,

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument and acknowledged that he or she executed it.

\_\_\_\_\_

My Commission Expires: \_\_\_\_\_

A copy has the same effect as the original.

Developed by the Executive Office on Aging, State of Hawai'i – Revised December 2000

