Health Care Proxy

(1) I, Bonze Anne Rose Blayk

hereby appoint Mark B. Finnigan
(name, home address and telephone number)
3783 Colegrove Rd.
Trumansburg NY 14886 607-342-1911

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 Christine M. Finnigan
(name, home address and telephone number)
3783 Colegrove Rd.
Trumansburg, NY 14886 227-7764

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)*:
– No Expiration Date –

(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 these proxies determine it is in my best interests to allow my life to end in order to ease my suffering, they have my approval. They may decide matters of nutrition and hydration. I wish to be allowed a natural death. In addition, if I display no measurable brain activity a do-not-resuscitate order will be posted.
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.

(5) Your Identification *(please print)*

Your Name Bonze Anne Rose Blayk

Your Signature BAnneBlayk Date 3/28/13

Your Address 1668 Trumansburg Rd., Ithaca, NY 14850

(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 Bonze Blayk Date 3/28/13

(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 3/28

Name of Witness 1
(print) JAY SKEZAS

Signature Jay Skezas

Address 1780 HANSHAW RD

ITHACA, NY 14850

Date 3/28/13

Name of Witness 2
(print) Kevin Moss

Signature Kevin Moss

Address 2133 ~~Middle~~ Mecklenburg Rd. Apt 3

Ithaca, NY 14850

NEW YORK state department of HEALTH