
# Roane State Community College
# Designation of Medical Surrogacy

In the event that I (Printed Name of Grantor) _____, become ill or injured and my decisional capacity is impaired, I hereby designate the following individual as my ***medical surrogate*** to act on my behalf to make health care decisions of me:

Name: _____

Telephone: _____
(Home) (Cell) (Work)

Address: _____
(Street Address) (City) (State) (Zip)

Email: _____ Relationship to Undersigned: _____

In the event of an immediate medical emergency (i.e. life threatening), or if the above-named individual refuses or is not able to act for me, the ***faculty member/director(s)*** _____ will become the first emergency contact and make the medical decision. Any prior designation is revoked.

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**THIS DOCUMENT MUST BE NOTARIZED BEFORE IT IS SUBMITTED**

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***I have read, understand and confirm that all of the information provided is accurate and complete.***

Participant's Signature_____ Date_____

Printed Participant's Name_____

Parent's Signature If Under Eighteen (18) _____

Before me, the undersigned authority came the Grantor, who is eighteen (18) years of age or older and acknowledged that he/she voluntarily dated and signed this writing, or directed it to be signed and dated as above. Done this _____ day of _____, 20 _____.

State of _____

County of _____

NOTARY PUBLIC _____

My Commission Expires: _____