APPOINTMENT OF SURROGATE
(TENNESSEE)

I, _________________________________ made the decision to appoint
Designated Physician _________________________________ as surrogate for
Name of Surrogate ________________________________
Name of Patient ________________________________

Surrogate Contact Information: Home: ________________________________
Work: ________________________________
Cell Phone: ________________________________

Reasons for Appointment (check all that apply):

____ Knows patient’s wishes
____ Knows patient’s best interest
____ Had regular contact with patient
____ Available and willing to serve
____ Demonstrates care and concern
____ Visits patient regularly during illness
____ Engages in face-to-face contact with caregiver
____ Participates in decision making process

Physician Signature ________________________________ Date/Time ________________________________

If designated physician is to act as surrogate, one of the following signatures must be obtained:

Ethics Committee Representative ________________________________ Date ________________________________
Concurring Second Physician ________________________________ Date ________________________________

Any individuals in disagreement? Yes ____ No ____
If yes, please explain ________________________________

________________________________________________
________________________________________________

ACCEPTANCE OF SURROGATE SELECTION

I accept the appointment as surrogate for ________________________________ Patient
and understand I have the authority to make all medical decisions.

Signature of Surrogate ________________________________ Date/Time ________________________________

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, May 3, 2005