**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**DEPARTMENT ON DISABILITY SERVICES**

## SUBSTITUTED CONSENT FOR HEALTH CARE DECISIONS

**For:** _____
Name of individual

Relationship to the above-named individual:

☐ I am a family member/relative of this individual. My relationship to this individual is
_____
_____.

☐ I am a pastor, clergy member or priest or other religious official that is involved with this individual's life. My relationship to this individual is
_____
_____.

☐ I am a close friend of this individual. My relationship to this individual is
_____
_____.

I **am willing** to provide substituted consent for health care decisions for this individual. I am providing my contact information below so that I can be kept informed of this individual's medical needs. I believe that I have had sufficient contact with this individual to be familiar with his/her activities, health care personal beliefs, and that I am thus qualified to make decisions on his/her behalf. I understand that, in making decisions on behalf of this individual, I will consider: the individual's current diagnosis and prognosis with and without the treatment at issue; expressed preferences regarding the type of treatment at issue; relevant religious and moral beliefs and personal values; behavior, attitudes, and past conduct with respect to the treatment at issue and medical treatment generally; reactions to the provision, or withholding or withdrawal of similar treatment to another individual; and expressed concerns about the effect on family or intimate friends of the individual if treatment were provided, withheld or withdrawn.

Please print or type the following:
**Name:** _____
**Address:** _____
**City/State/Zip Code:** _____
**Telephone Number(s):** _____

_____
**Signature** **Date**

_____
**Notary Public**
**Sworn to and subscribed to before me this _____ day of_____**

**20___.**

**My commission expires on: _____**