

**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):

- |   |   |
|---|---|
| <input type="checkbox"/> Knows patient's wishes           | <input type="checkbox"/> Demonstrates care and concern                  |
| <input type="checkbox"/> Knows patient's best interest    | <input type="checkbox"/> Visits patient regularly during illness        |
| <input type="checkbox"/> Had regular contact with patient | <input type="checkbox"/> Engages in face-to-face contact with caregiver |
| <input type="checkbox"/> Available and willing to serve   | <input type="checkbox"/> 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**      **or**      \_\_\_\_\_  
**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**