

Advance Health Care Directive Witness Form

Statement to be completed by Ombudsman-witness & Returned to Ombudsman Office

Resident Name _____

RACE: _____ PAY STATUS _____ TIME SPENT: _____ (minutes)

AGE: Over 75 Under 60 (circle one) TRAVEL TIME: _____ (minutes)

Facility Name _____ Phone _____

Address _____
Street, City, ZIP

Ombudsman Name _____

1. I believe this resident is capable of signing the document willfully, voluntarily, and with knowledge of what he/she is doing. Yes _____ No _____

If no, please explain:

2. The resident signed the document and indicated that I was serving as an Ombudsman-witness. Yes _____ No _____

3. I signed the document and indicated that I was serving as an Ombudsman-witness.

Yes _____ No _____

If no, please explain:

Second Witness: _____
Name

Relationship to Resident

Ombudsman: _____ Date _____
Signature

Printed name