NOTICE OF FILING PETITION TO APPOINT HEALTH CARE REPRESENTATIVE

State Form 45143 (R3 / 9-06) / OGC 0015

STATE OF INDIANA)
)
COUNTY OF _____)
)
IN THE MATTER OF)
)
THE HEALTH CARE REPRESENTATIVE FOR)
)
_____)

SS:

IN THE _____ COURT

PROBATE DIVISION

CAUSE NUMBER: _____

TO: _____

_____

_____

This matter will be determined at _____ o'clock on _____, 20_____, if no objection is heard in the Probate Division of the _____ Court in _____, Indiana.

At the hearing, the Court will decide whether the individual, _____, is an incapacitated person under Indiana law. This proceeding may substantially affect this person's rights. The Court will hold this hearing for the purpose of determining whether a health care representative should be appointed for that individual. **A copy of the Petition requesting appointment of a health care representative is attached to this Notice.**

The Petition may be heard and determined in the absence of that individual if the Court determines that his or her presence is not required. If the individual attends the hearing, opposes the Petition and is not represented by an attorney, the Court may appoint an attorney and/or guardian ad litem to represent the individual at the hearing.

The Court may, on its own motion or on request of any interested person, postpone the hearing to another date and time. You may appear at this hearing and be heard by the Court. If you do not appear, the Petition will be heard and acted upon by the Court in your absence.

Date (*month, day, year*)

Attorney for petitioner	Attorney number
Address of attorney (*number and street, city, state, and ZIP code*)	

Typed name of petitioner
Address of petitioner (*number and street, city, state, and ZIP code*)

CERTIFICATE OF SERVICE

I hereby certify that I mailed, by first-class mail, a copy of this Notice and the Petition for the Appointment of Health Care Representative to the person whose name and address is set forth above.

Signature of clerk	Name of court	Date (*month, day, year*)