Advance Health Care Directive

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

PART 1 – POWER OF ATTORNEY FOR HEALTH CARE

Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

(1.1) DESIGNATION OF AGENT: I, _____, designate the following individual as my agent to make health care decisions for me: (insert your name)

Name of individual you choose as agent: _____

Address: _____

_____

Telephone: _____

(home phone) *(work phone)*

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate agent(s):

Name of individual you choose as alternate agent: _____

Address: _____

_____

Telephone: _____

(home phone) *(work phone)*

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone: _____

(home phone) *(work phone)*

***(1.2) AGENT'S AUTHORITY**:* My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

_____

***(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE*:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

If I mark this box ❑, my agent's authority to make health care decisions for me takes effect immediately. Initial here_____

***(1.4) AGENT'S OBLIGATION**:* My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent. I understand that, by law, my agent may not consent to committing me to or placing me in a mental health treatment facility, or to convulsive treatment, psychosurgery, sterilization or abortion.

***(1.5) AGENT'S POSTDEATH AUTHORITY*:** My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

_____

***(1.6) NOMINATION OF CONSERVATOR**:* If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2 – INSTRUCTIONS FOR HEALTH CARE

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making medical treatment decisions including but not limited to end of life treatment decisions, you need not fill out Part 2 of this form.

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) MEDICAL TREATMENT DESIRES AND LIMITATIONS (OPTIONAL)*:*

I do **not** want efforts to prolong my life and I do **not** want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of the treatment outweigh the expected benefits. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and the quality of my life, as well as the extent of the possible prolongation of my life.

If this statement reflects your desires, initial here: _____

Other or additional statements of medical treatment desires and limitations:

_____

_____

_____

(You may attach additional pages if you need more space to complete your statements. Each additonal page must be dated and signed at the same time you date and sign this document.)

Relief From Pain: Except as I state in the following space, I direct that treatment for alleviation of pain discomfort be provided at all times, even if it seems to hasten my death:

_____

_____

_____

_____

(Add additional sheets if needed.)

PART 3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

You can express an intention to donate your bodily organs and tissues following your death.

(3.1) *UPON MY DEATH* (mark applicable box):

- ❑ I give any needed organs, tissues, or parts, OR
- ❑ I give the following organs, tissues, or parts only _____.
- ❑ I decline to give organs, tissues or parts for cosmetic surgery.
- ❑ I decline to give organs, tissues or parts for use outside of the United States.
- ❑ I decline to give organs, tissues or parts by for-profit tissue processors
- ❑ I decline to be an organ or tissue donor.

PART 4 – SIGNATURE

After completing this form, sign and date the form.

(4.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

***(4.2) SIGNATURE*:** Sign and date the form here:

Date: _____

Name: _____ _____

(Sign your name) *(Print your name)*

Address: _____

_____

(4.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California: (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, 3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness Name: _____

Address: _____

_____

Signature of Witness: _____

Date: _____

Second Witness Name: _____

Address: _____

_____

Signature of Witness: _____

Date: _____

(4.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

PART 5 – SPECIAL WITNESS REQUIREMENT

The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

(5.1) PATIENT IN A SKILLED NURSING FACILITY: The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the followingstatement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: _____

Name: _____ _____
(Sign your name) *(Print your name)*

Address: _____

_____

You may use this certificate of acknowledgment before a notary public instead of the statement of witnesses.

State of California }
} SS.
County of _____ }

On *(date)* _____, before me, *(name and title of officer)* _____,

personally appeared *(name(s) of signer(s)* _____

❑ personally known to me OR ❑ proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal. (Civil Code Section 1189.)

Signature of Notary: _____