Alaska Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will (Instructions for Health Care)
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care Decisions)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Instructions For Health Care)

If you are satisfied to allow the person that you select later in this document as your health care agent to determine what is best for you in making health care decisions, you do not need to fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want. There is a state protocol that governs the use of do not resuscitate orders by physicians and other health care providers. You may obtain a copy of the protocol from the Alaska Department of Health and Social Services. A 'do not resuscitate order' means a directive from a licensed physician that emergency cardiopulmonary resuscitation should not be administered to you.

END-OF-LIFE DECISIONS. Except to the extent prohibited by law, I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: **(Initial only one box.)**

[ ] Choice To Prolong Life: I want my life to be prolonged as long as possible within the limits of generally accepted health care standards; OR

[ ] Choice Not To Prolong Life: I want comfort care only and I do not want my life to be prolonged with medical treatment if, in the judgment of my physician, I have
(check all choices that represent your wishes)

[ ] a condition of permanent unconsciousness: a condition that, to a high degree of medical certainty, will last permanently without improvement; in which, to a high degree of medical certainty, thought, sensation, purposeful action, social interaction, and awareness of myself and the environment are absent; and for which, to a high degree of medical certainty, initiating or continuing life-sustaining procedures for me, in light of my medical outcome, will provide only minimal medical benefit for me; or

[ ] a terminal condition: an incurable or irreversible illness or injury that without the administration of life-sustaining procedures will result in my death in a short period

of time, for which there is no reasonable prospect of cure or recovery, that imposes severe pain or otherwise imposes an inhumane burden on me, and for which, in light of my medical condition, initiating or continuing life-sustaining procedures will provide only minimal medical benefit;

[ ] Additional instructions:

Artificial Nutrition and Hydration. If I am unable to safely take nutrition, fluids, or nutrition and fluids **(Initial your choices and/or write your instructions)**.

[ ] I wish to receive artificial nutrition and hydration indefinitely;

[ ] I wish to receive artificial nutrition and hydration indefinitely, unless it clearly increases my suffering and is no longer in my best interest;

[ ] I wish to receive artificial nutrition and hydration on a limited trial basis to see if I can improve;

[ ] In accordance with my choices above, I do not wish to receive artificial nutrition and hydration.

[ ] Other instructions:

Relief from Pain. **(Initial your choices and/or write your instructions)**.

[ ] I direct that adequate treatment be provided at all times for the sole purpose of the alleviation of pain or discomfort; or

[ ] I give these instructions:

(Write your instructions if applicable). Should I become unconscious and I am pregnant, I direct that:

OTHER WISHES. **(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.)**
I direct that

Conditions or limitations:

(Add additional sheets if needed.)

Selection of Health Care Agent
(Durable Power of Attorney for Health Care Decisions)

DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____ (name of individual you choose as agent)

_____ (address)

_____ (home telephone) (work telephone)

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: 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 first alternate agent

_____ (name of individual you choose as first alternate agent)

_____ (address)

_____ (home telephone) (work telephone)

OPTIONAL - DESIGNATION OF SECOND ALTERNATE AGENT: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent

_____ (name of individual you choose as second alternate agent)

_____ (address)

_____ (home telephone) (work telephone)

AGENT'S AUTHORITY. My agent is authorized and directed to follow my individual instructions and my other wishes to the extent known to the agent in making all health care decisions for me. If these are not known, my agent is authorized to make these decisions in accordance with my best interest, including decisions to provide, withhold, or withdraw artificial hydration and nutrition and other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

Under this authority, 'best interest' means that the benefits to you resulting from a treatment outweigh the burdens to you resulting from that treatment after assessing
(1) the effect of the treatment on your physical, emotional, and cognitive functions; and
(2) the degree of physical pain or discomfort caused to you by the treatment or the withholding or withdrawal of the treatment; and
(3) the degree to which your medical condition, the treatment, or the withholding or withdrawal of treatment, results in a severe and continuing impairment; and
(4) the effect of the treatment on your life expectancy; and
(5) your prognosis for recovery, with and without the treatment; and
(6) the risks, side effects, and benefits of the treatment or the withholding of treatment; and
(7) your religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE. Except in the case of mental illness, 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. In the case of mental illness, unless I mark the following box, my agent's authority becomes effective when a court determines I am unable to make my own decisions, or, in an emergency, if my primary physician or another health care provider determines I am unable to make my own decisions. If I mark this box, my agent's authority to make health care decisions for me takes effect immediately.

AGENT'S OBLIGATION. My agent shall make health care decisions for me in accordance with this durable power of attorney for health care, AND any instructions I give in my living will portion 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.

NOMINATION OF GUARDIAN. If a guardian 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 guardian, I nominate the alternate agents whom I have named above, in the order designated.

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**		
[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will (Instructions for Health Care)
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care Decisions)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____
On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above and I am not appointed as the health care agent or attorney-in-fact. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent(s) and Attorney(s)-in-Fact for Health Care Decisions.

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care Decisions:

Signature of Agent _____ Date _____

Signature of First Alternate Agent _____ Date _____

Signature of Second Alternate Agent _____ Date _____