Arizona 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
[ ] Selection of Health Care Agent (Health Care Power of Attorney)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will

Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should *initial* that statement. Read all of these statements carefully before you initial your selection. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. **You may initial any combination of paragraphs (1), (2), (3), and (4), but if you initial paragraph (5), the others should not be initialed.**

[ ] 1. If I have a terminal condition I do NOT want my life to be prolonged and I do NOT want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

[ ] 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I DO want the medical treatment necessary to provide care that would keep me comfortable, but I do NOT want the following **(Initial your choices, if desired)**:

- [ ] (a) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock, and artificial breathing.
- [ ] (b) Artificially-administered food and fluids.
- [ ] (c) To be taken to a hospital if at all avoidable.

[ ] 3. Notwithstanding my other directions, if I am known to be pregnant, I do NOT want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

[ ] 4. Notwithstanding my other directions, I DO want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

[ ] 5. I want my life to be prolonged to the greatest extent possible.

Other or Additional Statements of Desires **(add other statements, if any. If none, state "none"):**

Selection of Health Care Agent (Health Care Power of Attorney)

I designate _____ (name), of _____ (address), as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital, and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent, and acting for myself
(Initial your choice):

I have [ ] **OR** I have NOT [ ] completed and attached a living will for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the living will.

This health care directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

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

Under Arizona law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. You may also authorize

your agent to do so or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law. Note: The donation elections you make in this health care power of attorney survive your death. If any of the statements below reflects your desire, initial on the line next to that statement. You do not have to initial any of the statements. If you do not check any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Arizona law. **(Initial your choice, if desired):**

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution: _____

_____ Pursuant to Arizona law, 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
[ ] Selection of Health Care Agent (Health Care Power of Attorney)
[ ] 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 has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care proxy or attorney-in-fact therein. 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 according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

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

Signature _____ Date _____