California 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 (Power of Attorney for Health Care)
[   ] Designation of Primary Physician
[   ] Organ Donation

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 of this form lets you 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. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

PART 2 of this form is a Power of Attorney for Health Care. Part 2 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. (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 co-worker.) 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; and
(5) Make anatomical gifts, authorize an autopsy, and direct the disposition of your remains.

PART 3 of this form lets you designate a physician to have primary responsibility for your health care.

PART 4 of this form lets you express an intention to donate your bodily organs and tissues following your death.

After completing this form, sign and date the form at the end. The form must be signed by two (2) qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, any other health care providers you may have, any health care institution at which you are receiving care, and 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.
You have the right to revoke this advance health care directive or replace this form at any time.

Part 1: Living Will (Instructions for Health Care)

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

END-OF-LIFE DECISIONS: 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 of the following two boxes):**

[ ] **Choice NOT To Prolong Life**. I do NOT want my life to be prolonged if:
(i) I have an incurable and irreversible condition that will result in my death within a relatively short time,
(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, **OR**
(iii) the likely risks and burdens of treatment would outweigh the expected benefits, **OR**

[ ] **Choice TO Prolong Life.** I DO want my life to be prolonged as long as possible within the limits of generally-accepted health care standards.

RELIEF FROM PAIN **(initial below if this is your choice):**

[ ] Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death.
(add exceptions and additional sheets as needed):

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. Add additional sheets if needed.)**
I direct that:

Part 2: Selection of Health Care Agent (Power of Attorney for Health Care)

DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me: ____ (name) of ____ (address).

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 healthcare to keep me alive, except as I state here **(add additional sheets if needed):**

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 *initial* the following box. **If I initial 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 power of attorney for health care, any instructions I give in Part 1 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.

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 4 of this form **(insert exceptions and additional sheets if needed)**:

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.

Part 3: 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).

Part 4: 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 (Power of Attorney for Health Care)
[ ] 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

Witness #1 Statement: I declare under penalty of perjury under the laws of California that:
(1) 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) the individual signed or acknowledged this advance directive in my presence;
(3) the individual appears to be of sound mind and under no duress, fraud, or undue influence;
(4) I am not a person appointed as an agent by this advance directive; and
(5) I am at least eighteen (18) years of age and 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, or an employee of an operator of a residential care facility for the elderly.

Signature of Witness ______________________________ Date ____________________

Printed Name of Witness __________________________

Witness #2 Statement: I declare under penalty of perjury under the laws of California that:
(1) 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) the individual signed or acknowledged this advance directive in my presence;
(3) the individual appears to be of sound mind and under no duress, fraud, or undue influence;
(4) I am not a person appointed as an agent by this advance directive; and
(5) 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.
I further declare under penalty of perjury under the laws of California that I am at least eighteen (18) years of age and 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, 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.

Second Witness Signature ______________________________ Date ___________________

Printed Name of Second Witness __________________________

Special Witness Requirement: 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 following statement:

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.

Special Witness Signature ______________________________ Date ___________________

Printed Name and Title of Special 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 ____________________