Advance Health Care Directive

Part 1: Power of Attorney for Health Care

(1) Designation of Agent: I _____, of _____, California, designate the following individual as my agent to make health care decisions for me:

_____
Name of Individual You Choose as Agent

_____
Address

_____
City State Zip Code

_____
Home Phone Work Phone

First Alternate Agent *[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 first alternate agent:

_____
Name of Individual You Choose as First Alternate Agent

_____
Address

_____
City State Zip Code

_____
Home Phone Work Phone

Second Alternate Agent *[Optional]***:** 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

_____
City State Zip Code

_____

Home Phone Work Phone

(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:

_____.

(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.

(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.

(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:

_____.

(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

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

(7) 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:

[ ] (a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits.

[ ] (b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(8) Relief From Pain: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:
_____.

(9) 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:
_____.

Part 3: Donation of Organs at Death

(10) Wishes for Organ Donation: Upon my death *[mark applicable box]*:
[ ] (a) I give any needed organs, tissues, or parts.
[ ] (b) I give the following organs, tissues, or parts only:
_____
[ ] (c) My gift is for the following purposes: *[delete any of the following you do not want]*
(1) Transplant
(2) Therapy
(3) Research
(4) Education

Part 4: Primary Physician

(11) Designation of Primary Physician: I designate the following physician as my primary physician:

_____
Name of Physician

_____
Address

_____
City State Zip Code

_____
Phone

Secondary Designation: 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 of Physician

_____

Address

_____

City State Zip Code

_____

Phone

Part 5: Signatures

(12) Effect of Copy: A copy of this form has the same effect as the original.

(13) Signature: Sign and date the form here.

Dated: _____

_____

Sign Your Name

_____

Print Your Name

Alternative #1: Witnesses

(14) 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

_____
Signature of Witness

_____
Print Name

_____
Address

_____
Date

Second Witness

_____
Signature of Witness

_____
Print Name

_____
Address

_____
Date

(15) Additional Statement of Witnesses: *[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

Alternative #2: Notarization
Certificate of Acknowledgment of Notary Public

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)
) SS
County of _____)

On _____, 20__, before me, _____

personally appeared _____,
who 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.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing is true and correct.

WITNESS my hand and official seal.

_____

Notary Public for the State of California

[NOTARY SEAL] My commission expires: _____

(16) 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 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.

_____

Signature of Patient Advocate or Ombudsman

_____

Print Name

_____

Address

_____

Date