ADVANCE HEALTH CARE DIRECTIVE

Explanation
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. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Instructions
Part 1 of this form 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 a different person to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Unless you state otherwise in this form, 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. Donate your organs, tissues, and parts; authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part 2 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. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

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.

You have the right to revoke this advance health care directive or replace this form at any time.

Name of Patient: _____

Date of Birth: _____

Part 1 – Power of Attorney for Health Care

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 an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Designation of Agent:

I designate the following person as my agent to make health care decisions for me:

Name of person you choose as agent: _____

Address: _____

_____

Telephone: _____

(home phone) *(work phone)* *(cell)*

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:

Name of person you choose as alternate agent: _____

Address: _____

_____

Telephone: _____

(home phone) *(work phone)* *(cell)*

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:

_____

_____

_____

(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. _____
(Initial here)

OR

My agent's authority to make health care decisions for me takes effect immediately. _____
(Initial here)

Agent's Obligation:

My agent must 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.

Agent's Postdeath Authority:

My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add 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. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agent whom I have named.

Part 2 – 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:

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,

_____
(Initial here)

OR

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

_____
(Initial here)

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:

_____

_____
(Add additional sheets if 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.) I direct that:

_____

_____

_____

(Add additional sheets if needed.)

Part 3 – Donation of Organs, Tissues, and Parts at Death (*Optional)*

Upon my death:

I give my organs, tissues, and parts. _____
(Initial here to indicate yes)

By initialing this line, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

OR

I do *not* authorize the donation of any organs, tissues or parts. _____
(Initial here)

OR

I give the following organs, tissues, or parts only: _____
_____

_____
(Initial here)

My donation is for the following purposes (strike any of the following you do not want):

Transplant _____ Research _____
(Initial here) *(Initial here)*

Therapy _____ Education _____
(Initial here) *(Initial here)*

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines: _____
_____

I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors.

It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.
   Yes _____ No _____
   (Initial here) *(Initial here)*
2. My donated tissue may be used for applications outside of the United States.
   Yes _____ No _____
   (Initial here) *(Initial here)*
3. My donated tissue may be used by for-profit tissue processors and distributors.
   Yes _____ No _____
   (Initial here) *(Initial here)*

If I leave Part 3 blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or on page 3 of this form.)

Part 4 – Primary Physician (Optional)
I designate the following physician as my primary physician:

Name of Physician: _____
Telephone: _____
Address: _____

OPTIONAL: 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: _____
Telephone: _____
Address: _____

Part 5 - Signature
The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

SIGNATURE:
Sign and date the form here:

Date: _____ Time: _____ AM / PM

Signature: _____
(patient)

Print name: _____
(patient)

Address: _____

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: _____ Telephone: _____
Address: _____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

SECOND WITNESS

Name: _____ Telephone: _____
Address: _____

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

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.

Date: _____ Time: _____ AM / PM

Signature: _____
(witness)

Print name: _____
(witness)

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 the document.

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California)
County of _____)
)

On *(date)*_____ before me, *(name and title of the officer)* _____
_____ personally appeared *(name(s) of signer(s))* _____, 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 paragraph is true and correct.

WITNESS my hand and official seal.

Signature: _____ [Seal]
(notary)

Part 6 – Special Witness Requirement
If you are a patient in a skilled nursing facility, 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.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient advocate or ombudsman)

Print name: _____
(patient advocate or ombudsman)

Address: _____

Civil Code Section 1189; Health and Safety Code Section 7158.3; Probate Code Section 4701