ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

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 is a power of attorney for health care. Part 1 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 an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (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 coworker.) 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:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
(b) Select or discharge health care providers and institutions.
(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

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. Space is also provided for you to add to the choices you have made or for you to write out 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.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. 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.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1.1) 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	City, State, ZIP Code
Home Phone	Work Phone

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

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

(1.2) 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:

(Add additional sheets if needed.)

(1.3) 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.

(1.4) 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.

(1.5) 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:

(Add additional sheets if needed.)

(1.6) 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.

(2.1) 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 I have an incurable and irreversible condition that will result in my death within a relatively short time, I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or the likely risks and burdens of treatment would outweigh the expected benefits, OR
- ❑ **(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.

(2.2) 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.)

(2.3) 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 AT DEATH
(OPTIONAL)

(3.1) Upon my death (mark applicable box):

- ❑ I give any needed organs, tissues, or parts, OR
- ❑ (b) I give the following organs, tissues, or parts only.

(c) My gift is for the following purposes (strike any of the following you do not want):
(1) Transplant (2) Therapy (3) Research (4) Education

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

Name Of Physician	Phone
Address	City, State Zip Code

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	Phone
Address	City, State Zip Code

PART 5	
(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.	
(5.2) SIGNATURE: Sign and date the form here:	Date
Sign Your Name	Print Your Name
Address	City, State Zip

(5.3) 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 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	SECOND WITNESS
Print Name	Print Name
Address	Address
City, State Zip	City, State Zip
Signature Of Witness	Signature Of Witness
Date	Date

(5.4) 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.

Signature Of Witness	**Signature Of Witness**

PART 6
SPECIAL WITNESS REQUIREMENT

(6.1) 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.

Date	Sign Your Name
Address	Print Your Name
City, State Zip	