ADVANCE HEALTH CARE DIRECTIVE

CALIFORNIA PROBATE CODE SECTIONS 4600 TO 4752, INCLUSIVE.

A COPY OF THIS FORM HAS THE SAME EFFECT AS THE ORIGINAL.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

1.1 MY PERSONAL INFORMATION

Full Legal Name: _____

Date of Birth: _____

Address: _____

(street address, city, state and zip code)

1.2 PRIMARY AGENT

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

Agent's Name: _____

Address: _____

Phone: _____

(indicate home, work, and/or cell phone)

FIRST ALTERNATE AGENT

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:

First Alternate Agent's Name: _____

Address: _____

Phone: _____

(indicate home, work, and/or cell phone)

SECOND ALTERNATE AGENT

If I revoke my agent's authority and the 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:

Second Alternate Agent's Name: _____

Address: _____

Phone: _____

(indicate home, work, and/or cell phone)

1.3 AGENT'S AUTHORITY

My agent will be allowed to make health care decisions for me just as I can presently make my own. For example, my agent may make decisions to (1) provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive. (2) Choose for me a particular physician or health care facility. (3) Receive or review my medical information and records, or permit release of my records for others' review.

1.4 WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

Initial on the line and then put an **X** in the box next to the sentence you agree with.

_____ ☐ (a) My agent's authority will take effect immediately to make health care decisions for me.

_____ ☐ (b) My agent will make health care decisions for me ONLY when I do not have the mental capacity to make my own health care decisions.

1.5 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.

1.6 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.

_____

_____

_____

_____

1.7 NOMINATION OF CONSERVATOR

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in his 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 out 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:

Initial on the line and then put an **X** in the box next to the sentence you agree with.

_____ ☐ (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, 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:

_____

_____

_____

_____

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.

_____

_____

_____

_____

PART 3
DONATION OF ORGANS AT DEATH

3.1 UPON MY DEATH

Initial on the line and then put an **X** in the box next to the sentence you agree with.

_____ ☐ (a) I do NOT wish to donate my organs.

_____ ☐ (b) I wish to donate my organs as follows:

☐ Give any needed organs, tissues, or parts.

☐ Give the following organs, tissues, or parts only:

_____

_____

_____

My gift is for the following purposes:

☐ Transplant ☐ Therapy ☐ Research ☐ Education

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

4.1 PRIMARY DOCTOR

I designate the following physician as my primary physician:

Physician's Name: _____

Address: _____

Phone: _____

(indicate office and/or cell phone)

ALTERNATE DOCTOR

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:

Physician's Name: _____

Address: _____

Phone: _____

(indicate office and/or cell phone)

PART 5
WITNESSES

THIS DOCUMENT MUST EITHER BE SIGNED BY TWO WITNESSES OR NOTARIZED.

5.1 YOUR SIGNATURE

Name: _____

Address: _____

Signature: _____ Date: _____

(sign your name in the presence of the witnesses)

5.2 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: _____

Address: _____

Signature: _____ Date: _____

SECOND WITNESS: _____

Address: _____

Signature: _____ Date: _____

5.3 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.

X _____ X _____

(signature of witness) (signature of witness)

PART 6
SPECIAL WITNESS REQUIREMENT

6.1 SKILLED NURSING FACILITY

Initial on the line and then put an **X** in the box next to the sentence you agree with.

_____ ☐ (a) I do NOT live at a skilled nursing facility.

If (a) is checked, then continue on to Part 7.

_____ ☐ (b) I live at a skilled nursing facility.

If (b) is checked, then complete the Special Witness section below.

6.2 SPECIAL WITNESS

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.

Name: _____
(print name of advocate or ombudsman)

Address: _____
(print address of advocate or ombudsman)

Signature: _____ Date: _____
(signature of advocate or ombudsman)

PART 7
NOTARY PUBLIC

THIS DOCUMENT MUST EITHER BE SIGNED BY TWO WITNESSES OR NOTARIZED.

7.1 ACKNOWLEDGEMENT OF NOTARY PUBLIC

I sign my name to this Advance Health Care Directive on _____
(date)

at _____ .
(city and state)

Signature: _____
(sign your name in the presence of the notary)

Name: _____

Address: _____

State of California **ACKNOWLEDGMENT** County of _____

On _____ before me,
(date)

_____ ,
(insert name and title of the officer)

personally appeared _____ ,
(print your name)

who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person 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)