CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

Name ______________________ **Date of birth** ______________________

PART 1 – 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 individual you choose as agent: ______________________

Address: ______________________

Home phone: ____________ Work phone: ____________ Cell 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 alternative agent: ______________________

Address: ______________________

Home phone: ____________ Work phone: ____________ Cell 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 alternative agent: ______________________

Address: ______________________

Home phone: ____________ Work phone: ____________ Cell phone: ____________

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:

(Initial) __________ My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

OR

(Initial) __________ 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 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 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.)

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.

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

(Initial) __________ 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

Choice To Prolong Life

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

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.)

3 – DONATION OF ORGANS AT DEATH (OPTIONAL)

PART I. Upon my death:

(Initial) __________ I give any needed organs, tissues, or parts.

OR

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

OR

(Initial) __________ I give the following organs, tissues, or parts only: ______________________________

____

If you wish to donate organs, tissues, or parts, you must complete parts II and III.

PART II. My gift is for the following purposes (initial all that you accept):

________ Transplant ________ Research ________Therapy ________ Education

PART III. 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 (initial your choice): _____ Yes _____ No

2. My donated tissue may be used for applications outside of the United States. _____ Yes _____ No

3. My donated tissue may be used by for-profit tissue processors and distributors. _____ Yes _____ No

(Health and Safety Code Section 7158.3)

PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician: ______________________ Phone: ______________________

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: ______________________ Phone: ______________________

Address: ______________________

PART 5 – SIGNATURE

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

PATIENT

Printed name: ______________________ Signature: ______________________

Address: ______________________

Date: ______________________ Time: ______________________

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

Printed name: ______________________ Signature: ______________________

Address: ______________________

Phone: ______________________ Date: ______________________ Time: ______________________

SECOND WITNESS

Printed name: ______________________ Signature: ______________________

Address: ______________________

Phone: ______________________ Date: ______________ Time: ______________

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.

Printed name: ______________________ Signature: ______________________

Address: ______________________

Date: ______________________ Time: ______________________

> 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]

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.

Printed name: ______________________ Signature: ______________________

Address: ______________________

Date: ______________________ Time: ______________________