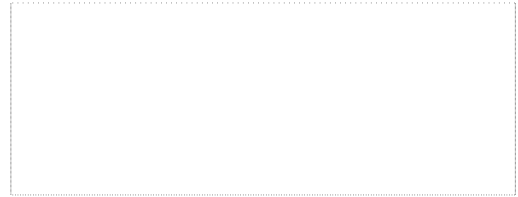




Patient Name _____

Date of Birth _____



ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form lets you name another individual as your healthcare agent to make healthcare 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 healthcare agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your healthcare agent may **not** be an operator or employee of a community care facility, a residential care facility where you are receiving care, your supervising healthcare provider or an employee of the healthcare institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your healthcare agent will have the right to:

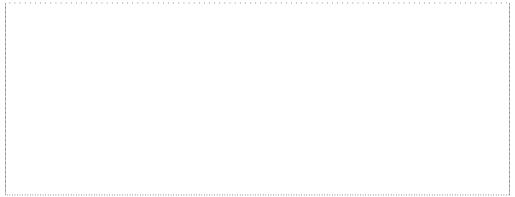
1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge healthcare providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of healthcare, including cardiopulmonary resuscitation.
5. Donate your organs, skin or tissue; authorize an autopsy and direct disposition of remains.

However, your healthcare agent **will not be able** to commit you to a mental health facility, 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 healthcare, whether or not you appoint a healthcare 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 healthcare agent to determine what is best for you in making end-of-life decisions for you, you **do not** need to fill out Part 2 of this form.

Give a copy of the signed and completed form to your physician, to any other healthcare providers you may have, to any healthcare institution at which you are receiving care, and to any healthcare agents you have named. You should talk to the person you have named as healthcare 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 Healthcare Directive or replace this form at any time.



PART 1
POWER OF ATTORNEY FOR HEALTHCARE

DESIGNATION OF HEALTHCARE AGENT

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

Name of individual you choose as a healthcare agent _____

Address _____

Telephone _____

Home

Work

Cell

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make healthcare decisions for me, I designate as my **first** alternate agent:

Name of individual you choose as **first** alternate healthcare agent _____

Address _____

Telephone _____

Home

Work

Cell

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 healthcare decision for me, I designate as my **second** alternate agent:

Name of individual you choose as **second** alternate healthcare agent _____

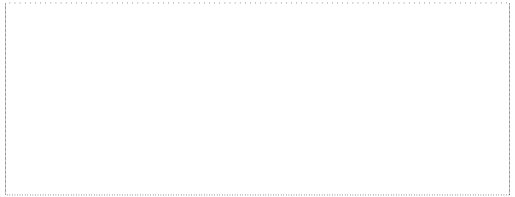
Address _____

Telephone _____

Home

Work

Cell



HEALTHCARE AGENT'S AUTHORITY

My healthcare agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of healthcare to keep me alive, except as I state here:

Add additional sheets if needed

WHEN HEALTHCARE AGENT'S AUTHORITY BECOMES EFFECTIVE

My healthcare agent's authority becomes effective when my primary physician determines that I am **unable** to make my own healthcare decisions.

initial here

OR

My agent's authority to make healthcare decisions for me takes effect **immediately**.

initial here

AGENT'S OBLIGATION

My healthcare agent shall make healthcare decisions for me in accordance with this power of attorney for healthcare, 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 healthcare 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.

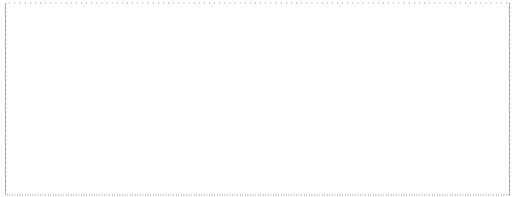
AGENT'S POST DEATH AUTHORITY

My healthcare 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 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 HEALTHCARE

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 healthcare providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with my choice I have marked below:

<p><i>Choice Not To Prolong Life</i></p> <p>I do not want my life to be prolonged if:</p> <ul style="list-style-type: none"> • 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 • the likely risks and burdens would outweigh the expected benefits 	<p>_____</p> <p>initial here</p>
--	----------------------------------

OR

<p><i>Choice To Prolong Life</i></p> <p>I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards.</p>	<p>_____</p> <p>initial here</p>
---	----------------------------------

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 AT DEATH (OPTIONAL)

I. Upon my death (*Initial applicable item*)

_____ I give any needed organs, tissues or parts

OR

_____ I do **NOT** authorize the donation of any organs, tissues or parts

OR

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

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

II. My gift is for the following purposes: (*Initial applicable items*)

_____ Transplant _____ Research

_____ Therapy _____ Education

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.

(*Initial applicable items*)

_____ Yes _____ No My donated skin may be used for cosmetic purposes

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

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

PART 4

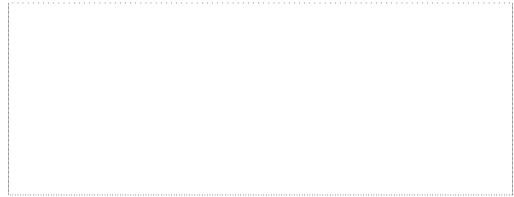
PRIMARY PHYSICIAN(S) (OPTIONAL)

I designate the following physician as my primary physician:

Print 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:

Print Name of Physician _____

Telephone _____

Address _____

PART 5
SIGNATURE

This form must be signed by you and by two qualifying witnesses or acknowledged before a notary public.

Sign and date the form here

Date _____ Time _____ AM/PM

Patient Signature _____

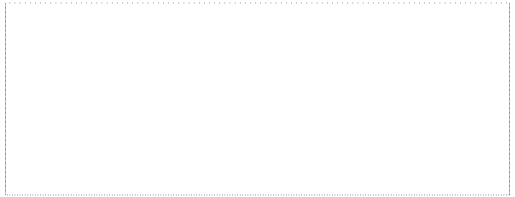
Patient Printed Name _____

Address _____

WITNESS STATEMENT

I declare under penalty of perjury under the laws of California that:

1. the individual who signed or acknowledged this Advance Healthcare Directive is personally known to me, or that the individual's identity was proven to me by convincing evidence
2. the individual signed or acknowledged this Advance Healthcare Directive in my presence
3. the individual appears to be of sound mind and under no duress, fraud, or undue influence
4. I am not a person appointed as agent by this Advance Healthcare Directive, and
5. I am not the individual's healthcare provider, an employee of the individual's healthcare 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

Date _____ Time _____ AM/PM

First Witness Signature _____

First Witness Printed Name _____

Address _____

Telephone _____
Home Work Cell

SECOND WITNESS

Date _____ Time _____ AM/PM

Second Witness Signature _____

Second Witness Printed Name _____

Address _____

Telephone _____
Home Work Cell

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 Healthcare 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

Witness Signature _____

Witness Printed Name _____



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.

(Civil Code § 1189)

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

NOTARY PUBLIC

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 _____
(*Notary Public*)

PLACE NOTARY SEAL ABOVE

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

Patient Advocate or Ombudsman Signature _____

Patient Advocate or Ombudsman Printed Name _____

Address _____
