ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

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. 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 ("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:

Sally R. Dough
(Name of Individual You Choose as Agent)

100 Main Street, Ourtown, CA 90000
(address) (city) (state) (ZIP Code)

(949) 555-0123 (949) 555-9999
(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:

John Q. Dough, Jr.
(name of individual you choose as first alternate Agent)

1000 First Street, Ourtown, CA 90000
(address) (city) (state) (ZIP Code)

(999) 555-2222 (999) 555-2111
(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:

Jane Dough Money
(name of individual you choose as second alternate Agent)

9999 Last Street, Ourtown, CA 90000
(address) (city) (state) (ZIP Code)

(999) 555-6789 (999) 555-5555
(home phone) (work phone)

(1.2) **AGENT'S AUTHORITY**: My Agent is authorized to make all health care decisions for me, whether relating to physical trauma or other medical conditions, or to psychiatric, psychological, or mental conditions, deficits, or disorders, including, without limitation: (a) decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive; (b) after consultation with any and all medical professionals which my Agent shall, in his or her sole reasonable discretion determine to be necessary in light of the circumstances, the right, power, and authority, without the necessity of obtaining court authority and without the interference of or consultation with any other third party, to disconnect any and all artificial life support systems of any nature if I have survived as a result of such artificial life support for a period of one (1) year in a coma, persistent vegetative state, or in any other state in which I have not been able to communicate or otherwise demonstrate conclusively that my cognitive abilities remain intact; and (c) without the necessity of any court conservatorship to make any all health care decisions on my behalf if, as a result of psychiatric, psychological, or mental disorder I am determined to be a danger to myself or others, or that I am gravely disabled, as defined in the California Welfare and Institutions Code, as amended from time to time, 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 POST-DEATH 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 **initialed** below:

(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.

_____
Initials

(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.

_____
Initials

(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 and initial next to your choice):

_____ (a) ☐ **NO DONATIONS.** If I have checked this box, I do NOT want to make any organ donations of any nature at my death.

_____ (b) ☐ I give any needed organs, tissues, or parts, OR

_____ (c) ☐ I give the following organs, tissues, or parts only.

_____

_____ (d) ☐ My anatomical gift is for any or all of the following purposes **EXCEPT (strike through any of the following you do not authorize and initial next to each item you strike through)**:

_____ (1) Transplant

_____ (2) Therapy

_____ (3) Research

_____ (4) Education

PART 4 -- PRIMARY PHYSICIAN (OPTIONAL)

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

_____
(Name of Physician)

_____
(Address) (City) (State) (ZIP Code)

()
_____
(Telephone)

PART 5 -- USE OF PHOTOCOPIES; SIGNATURE

(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:

April 28, 2006
(Sign your name here) (Date)

John Q. Dough
(Printed name)

100 Main Street	Ourtown	CA	90000
(Address)	(City)	(State)	(ZIP Code)

NOTARIAL ACKNOWLEDGMENT

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On April 28, 2006, before me, Sam N. Otary, Notary Public of the State of California, personally appeared John Q. Dough, personally known to me (or 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 executed the same in his authorized capacity, and that by his signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

Signature _____
Notary Public

(Seal)