ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code§ 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 I 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 provisions, 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.

After completing this form, sign and date the form at the end and have your signature notarized. You may wish to 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 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

I revoke all prior advance health care directives and durable powers of attorney for health care signed by me. This document shall not be affected by my subsequent incapacity. I am not a patient in a skilled nursing facility, and I am not a conservatee.

1.1 NAME AND ADDRESS OF PRINCIPAL. My name, address and date of birth are:

Name: ____________________________
Address: ____________________________
Date of Birth: ____________________________

1.2 DESIGNATION OF AGENTS.

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

Name: ____________________________
Address: ____________________________
Phone No.: Home (___) Work (___)
Cell/Pager: (___) Fax (___)

b. 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:

Name: ____________________________
Address: ____________________________
Phone No.: Home (___) Work (___)
Cell/Pager: (___) Fax (___)

Cc. SECOND ALTERNATE AGENT. 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.

Name: ____________________________
Address: ____________________________
Phone No.: Home (___) Work (___)
Cell/Pager: (___) Fax (___)

1.3 AGENT'S AUTHORITY. Unless I otherwise specify, 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.

I A WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE. Unless I otherwise specify, that agent will make health care decisions for me in the future, if and when I no longer have the mental capacity to make my own health care decisions. My primary care physician will determine when I am unable to make health care decisions for myself.
1.5 AGENT'S OBLIGATION. My agent shall make health care decisions for me in accordance with this power of attorney for health care 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 POST-DEATH AUTHORITY. Unless I specify otherwise, my agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains.

1.7 NOMINATION OF A CONSERVATOR. If a Conservator of my person needs to be appointed for me by a court, I nominate as Conservator of my person those persons appointed as my agent, in order above.

PART 2: INSTRUCTIONS FOR HEALTH CARE

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. I Choose NOT to Prolong Life. If I initial this line, I do not want my life to be prolonged and I do not want life-sustaining treatment to be provided or continue if any of the following conditions apply:
   (1) I am in a coma or persistent vegetative state which two qualified physicians who are familiar with my condition have diagnosed as irreversible (that is, there is no reasonable possibility that I will regain consciousness).
   (2) I am terminally ill and the use of life sustaining procedures would only serve to artificially delay the moment of my death.
   (3) I have an incurable and irreversible condition that will result in my death within a relatively short time.
   (4) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness.
   (5) The likely risks and burdens of treatment outweigh the expect benefits. In such circumstances, I authorize my agent to sign a request to forego resuscitative measures, including a "do not resuscitate" ("DNR") form.

___ b. I Choose To Prolong Life: If I initial this line, 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. I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

2.3 SPECIAL INSTRUCTIONS. _______________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
PART 3: DONATION OF ORGANS AT DEATH

3.1  a. NO DONATIONS. If I initial this line, I do NOT want any organs, tissues or parts donated following my death; OR

  b. MAXIMUM DONATION AUTHORITY. If I initial this line, I authorize my agent to give any needed organs, tissues, or parts following my death; OR

  c. LIMITED DONATION AUTHORITY. If I initial this line, I give the following organs, tissues, or parts only following my death:

  d. SPECIFIC PURPOSES. If I initial this line and I have authorized any donations, my gift is for the following purposes only (I will line through any of the following purposes that I do not want):

    (1) Transplant  (2) Therapy  (3) Research  (4) Education

PART 4: DISPOSITION OF REMAINS

A. Burial.  

  If I initial this line, I direct that my remains shall be buried.

B. Cremation.  

  If I initial this line, I direct that my remains shall be cremated.

PART 5: INSPECTION AND DISCLOSURE OF PHYSICAL OR MENTAL HEALTH INFORMATION

Subject to any limitations contained herein, my agent is authorized to:

1. Request, review and receive any information, oral or written, regarding my physical or mental health, including but not limited to medical and hospital records;

2. Execute releases or other documents required to obtain this information;

3. Consent to the disclosure of physical or mental health information;

4. Receive into my agent's sole possession any personal property and effects recovered from or about my person by any hospital, police agency or any person during my illness, disability, or at my death, including my remains, if applicable.
PART 6: EFFECT OF COPY

6.1 A PHOTOCOPY OR ACSIMILE OF THIS FORM HAS THE SAME EFFECT AS THE ORIGINAL

I sign my name to this Advance Health Care Directive at ______________________ ______________________

(City) (State)

on, ______________________ (Date) (Signature of Principal)

This Advance Health Care Directive will not be valid unless it is either (1) signed by two qualified adult
witnesses who are present when you sign or acknowledge your signature or (2) acknowledged before a
notary public in California. If you use witnesses rather than a notary public, the law prohibits using the
following as witnesses: (1) the persons you have appointed as your agent or alternate agent(s); (2) your
health care provider or an employee of your health care provider; or (3) an operator or employee of an
operator of a community care facility or residential care facility for the elderly. Additionally, at least one
of the witnesses cannot be related to you by blood, marriage or adoption, or be named in your will, or by
operation of law be entitled to any portion of your estate upon your death.

I declare under penalty of perjury under the laws of the California that the person who signed or
acknowledged this document is personally known to me to be the principal, or that the identity of the
principal was provided to me by convincing evidence; that the principal signed or acknowledged this
durable power of attorney in my presence, that the principal appears to be of sound mind and under no
duress, fraud, or undue influence; that I am not the person appointed as attorney in fact by this
document; and that I am not the principal's health care provider, an employee of the principal's health

care provider, the operator of a community care facility or a residential care facility for the elderly, nor
an employee of an operator of a community care facility or residential care facility for the elderly.

First Witness:

Signature ______________________

Print Name ________________________________________________

Date ______________________

Residence Address __________________________________________

Second Witness:

Signature ______________________

Print Name ________________________________________________

Date ______________________

Residence Address __________________________________________

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 principal by blood,
marriage, or adoption, and, to the best of my knowledge I am not entitled to any part of the estate of the principal
upon the death of the principal under a will now existing or by operation of law.

Signature ________________________________________________