

# ADVANCE HEALTH CARE DIRECTIVE

## California Probate Code section 4701

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.

### INSTRUCTIONS

#### PART 1 - POWER OF ATTORNEY

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:

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 health care 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 health care, including cardiopulmonary resuscitation.
5. Make anatomical gifts, authorize an autopsy and direct disposition of remains.

#### PART 2 - INSTRUCTIONS FOR HEALTH CARE

You can 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. You also can add to the choices you have made or 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 - DONATION OF ORGANS

You can express an intention to donate your bodily organs and tissues following your death.

#### PART 4 - PRIMARY PHYSICIAN

You designate a physician to have primary responsibility for your health care.

#### PART 5 - SIGNATURE

After completing this form, sign and date the form at the end.

**PART 6 - SPECIAL WITNESS REQUIREMENT**

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:

Name of individual you choose as agent: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
(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:

Name of individual you choose as agent: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
(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 second alternate agent:

Name of individual you choose as agent: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_  
(home phone) (work phone)

(1.2) **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 necessary)

(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. \_\_\_\_\_ (Initial here)

**OR**

My agent's authority to make health care decisions for me takes effective immediately \_\_\_\_\_ (Initial here)

(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 have 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 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 necessary)

(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 marked below:

Choice NOT TO Prolong Life: \_\_\_\_\_ (Initial here)

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 here)

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 treatments for alleviation of pain or discomfort be provided at all times, event if it hastens my death:

---

---

---

---

(Add additional sheets if necessary)

(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 necessary)

**PART 3 - DONATION OF ORGANS AT DEATH (OPTIONAL)**

(3.1) Upon my death:

I give any needed organs, tissues or parts \_\_\_\_\_  
(Initial here)

OR

I give the following organs, tissues or parts only: \_\_\_\_\_  
(Initial here)

My gift is for the following purposes:

Transplant \_\_\_\_\_  
(Initial here)

Therapy \_\_\_\_\_  
(Initial here)

Research \_\_\_\_\_  
(Initial here)

Education \_\_\_\_\_  
(Initial here)

**PART 4 - PRIMARY PHYSICIAN (OPTIONAL)**

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

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

*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: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**PART 5 - 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:

Date: \_\_\_\_\_

Name: \_\_\_\_\_

(Sign Your Name)

\_\_\_\_\_

(Print Your Name)

Address: \_\_\_\_\_

*(5.3) 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**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**SECOND WITNESS**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

(5.4) **ADDITIONAL STATEMENT OF WITNESS:** 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 adoptions, 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.

Signature of Witness: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

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

State of California )  
County of \_\_\_\_\_ ) ss  
)

On (date) \_\_\_\_\_, before me, (name and title of officer) \_\_\_\_\_

personally appeared (name of signer(s)) \_\_\_\_\_

personally known to me OR  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 signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal. (Civil Code Section 1189)

Signature of Notary: \_\_\_\_\_

**PART 6 - SPECIAL WITNESS REQUIREMENT**

(6.1) 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 §4675 of the Probate Code.

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(Sign Your Name) (Print Your Name)

Address: \_\_\_\_\_  
\_\_\_\_\_

Usted puede usar este certificado de confirmación ante notario público en vez de la declaración de testigos.

State of California )  
 )  
 )

County of \_\_\_\_\_

On (date) \_\_\_\_\_ before me, (here insert name and title of the officer) \_\_\_\_\_

personally appeared (name(s) of signer(s)) \_\_\_\_\_,

personally known to me (or 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.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature of Notary: \_\_\_\_\_ (Seal)

**PARTE 6 – REQUERIMIENTO DE TESTIGO ESPECIAL**

Si usted es paciente en un establecimiento con servicio de enfermería especializada, el abogado o defensor cívico del paciente debe firmar la siguiente declaración:

**DECLARACIÓN DEL ABOGADO O DEFENSOR CÍVICO DEL PACIENTE**

Declaro bajo pena de perjurio conforme a las leyes de California que soy abogado o defensor cívico del paciente designado por el Departamento de la Senectud del Estado y que estoy sirviendo como testigo como lo estipula la Sección 4675 del Código Testamentario.

Fecha: \_\_\_\_\_

Nombre: \_\_\_\_\_  
(ponga su firma) (escriba su nombre con letra de molde)

Dirección: \_\_\_\_\_  
\_\_\_\_\_