

**THIS ADVANCE DIRECTIVE, dated \_\_\_\_\_, REVOKES ALL  
PRIOR ADVANCE DIRECTIVES**

**Advance Health Care Directive**

*(in accordance with California Probate Code Sections 4600-4805)*

**PROTECTING YOUR HEALTH CARE FUTURE**

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. 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: Power of Attorney for Health Care**

(1.1) Designation of agent:

*(Fill in below the name and contact information of the person and alternate persons you wish to make health care decisions for you if you become incapacitated. You should make sure this person agrees to accept this responsibility. 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.) If you choose to name an agent, you should discuss your wishes with that person and give him/her a copy. If you choose not to name an agent, just draw a line through the spaces below and go on to Part 2.)*

I, \_\_\_\_\_ hereby appoint:

name \_\_\_\_\_

address \_\_\_\_\_

home phone (\_\_\_\_) \_\_\_\_\_ work phone (\_\_\_\_) \_\_\_\_\_ cell phone (\_\_\_\_) \_\_\_\_\_

email address \_\_\_\_\_

as my agent to make health care decisions for me as authorized in this document.

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:

*OPTIONAL:* name \_\_\_\_\_

address \_\_\_\_\_

home phone (\_\_\_\_) \_\_\_\_\_ work phone (\_\_\_\_) \_\_\_\_\_

cell phone (\_\_\_\_) \_\_\_\_\_ email address \_\_\_\_\_

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:

*OPTIONAL:* name \_\_\_\_\_

address \_\_\_\_\_

home phone (\_\_\_\_) \_\_\_\_\_ work phone (\_\_\_\_) \_\_\_\_\_

cell phone (\_\_\_\_) \_\_\_\_\_ email address \_\_\_\_\_

(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:

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(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 have given 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:

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(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 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:

(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, OR

(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.

(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:

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(add additional sheets if needed)

(2.3) Other Wishes: (If you do not agree with any of the optional choices 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:

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(add additional sheets if needed)

**Part 3: Donation of Organs at Death (optional)**

(3.1) Upon my death (mark applicable box):

- (a) I give any needed organs, tissues, or parts, OR
- (b) I give the following organs, tissues, or parts only.

(c) My gift is for the following purposes (strike any of the following you do not want):

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

**Part 4: Primary Physician (Optional)**

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

(name & phone # of physician) \_\_\_\_\_

(address, city, state, zip) \_\_\_\_\_

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 & phone # of physician) \_\_\_\_\_

(address, city, state, zip) \_\_\_\_\_

**Part 5:**

(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) \_\_\_\_\_ (sign your name) \_\_\_\_\_

(print your name) \_\_\_\_\_

(address, city, state, zip) \_\_\_\_\_

(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 health care 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 health 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:  
(print name) \_\_\_\_\_  
(address) \_\_\_\_\_  
(city, state) \_\_\_\_\_  
  
(signature) \_\_\_\_\_  
(date) \_\_\_\_\_

Second Witness:  
(print name) \_\_\_\_\_  
(address) \_\_\_\_\_  
(city, state) \_\_\_\_\_  
  
(signature) \_\_\_\_\_  
(date) \_\_\_\_\_

(5.4) At least one of the witnesses must 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. (signature) \_\_\_\_\_

(Document may be notarized instead of witnessed if desired).

**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 Section 4675 of the Probate Code.

(date) \_\_\_\_\_ (sign your name) \_\_\_\_\_  
(address, city, state) \_\_\_\_\_  
(print your name) \_\_\_\_\_