Advance Health Care Directive

Including Power of Attorney for Health Care Decisions
California Probate Code Sections 4600-4805

MY HEALTH CARE WISHES

This form lets you give instructions about your future health care. It also lets you name someone to make decisions for you if you can't make your own decisions. It's best if you fill out the whole form, but, as long as it is signed, dated and witnessed or notarized properly, you may choose only to appoint an agent (Section 1) or provide health care instructions (Section 3). Your agent may need this document immediately in case of an emergency. You should keep the completed original and give copies of it to (1) your agent and alternate agents, (2) your physician(s), (3) members of your family and others who might be called in the event of a medical emergency, and (4) any hospital or other health facility where you receive treatment. A copy of a fully executed Advance Health Care Directive has the same effect as the original.

You may revoke any part of or this entire Advance Health Care Directive at any time. To revoke the appointment of an agent, you must inform your treating health care provider personally or in writing. Completing a new California Medical Association Advance Health Care Directive will revoke all previous directives.

If there is anything in this form you do not understand, read the booklet that comes with this form and the italicized instructions on the form, or ask your physician, other health care professional or an attorney for help. You may also review additional information and instructions concerning advance health care directives on the California Medical Association's website, www.cmanet.org.

1. APPOINTMENT OF HEALTH CARE AGENT

☐ **OPTIONAL:** I, _____, wish to appoint a health care agent.

(Print your full name and date of birth)

The name and contact information of the person I appoint as agent and alternate agent(s) are indicated on page 2.

If you do not want to appoint a health care agent, skip to Section 3.

Your agent may **NOT** *be:*

A. Your primary treating health care provider.
B. An operator of a community care or residential care facility where you receive care.
C. An employee of the health care institution or community or residential care facility where you receive care, unless your agent is related to you or is one of your co-workers.

If you choose to name an agent, you should discuss your wishes with that person and make sure that person understands and accepts the responsibility of being your agent for health care decisions. Give that person a copy of this form once completed.

I hereby appoint as my agent to make health care decisions for me:

Name (agent's name): _____

Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone/Pager: (_____) _____ Fax: (_____) _____

I understand this appointment will continue unless I revoke it.

If I revoke my agent's authority or if my agent is not reasonably available, able or willing to make health care decisions for me, I appoint the following person(s) as my alternate agent(s) to make health care decisions for me, listed in the order they should be asked unless revoked by me:

OPTIONAL: 1st alternate agent:

Name (agent's name): _____

Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone/Pager: (_____) _____ Fax: (_____) _____

OPTIONAL: 2nd alternate agent:

Name (agent's name): _____

Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone/Pager: (_____) _____ Fax: (_____) _____

2. AUTHORITY OF AGENT

Your agent must make health care decisions that are consistent with the instructions in this document and your known wishes. It is important that you discuss your health care desires with the person(s) you appoint as your health care agent, alternate agent(s), and with your doctor(s). If your wishes are not known, your agent must make health care decisions that your agent believes to be in your best interest, considering your personal values to the extent they are known. Below, you can specify what authority your agent has and when that authority takes effect.

If my primary physician finds that I cannot make my own health care decisions, I grant my agent full power and authority to make those decisions for me, subject to any health care instructions set forth below. My agent will have the right to:

A. Consent, refuse consent, or withdraw consent to any medical treatment, procedure or services, such as tests, drugs, surgery, or consultations for any physical or mental condition. This includes the provision, withholding or withdrawal of artificial nutrition and hydration (feeding by tube or vein) and all other forms of health care, including cardiopulmonary resuscitation (CPR).

B. Choose or reject my physician, other health care professionals or health care facilities.

C. Receive and consent to the release of medical information as permitted by HIPAA and the California Confidentiality of Medical Information Act.

D. Donate organs or tissues, authorize an autopsy and dispose of my body, unless I have said something different in a contract with a funeral home, in my will, through Donate Life California Organ and Tissue Donor Registry or by some other written method.

I understand that, by law, my agent may not consent to committing me to or placing me in a mental health treatment facility, or to convulsive treatment, psychosurgery, sterilization or abortion, and may not request an aid-in-dying drug on my behalf.

I understand that I can specify when my agent's authority to make health care decisions for me begins, either: (1) only when I become unable to make health care decissions for myself, or (2) immediately, even though I am still able to make health care decisions for myself.

I understand that my agent's authority to make health care decisions for me will begin only when I become unable to make health care decisions for myself, unless I choose to make my agent's authority effective immediately, as indicated by my signature below:

☐ **OPTIONAL: I choose to make my agent's authority effective immediately.**

_____

(Signature ONLY if you want agent's authority to be effective immediately.)

3. HEALTH CARE INSTRUCTIONS

You may, but are not required to, state your desires about the goals and types of medical care you do or do not want, including your desires concerning life support if you are seriously ill. If your wishes are not known, your agent must make health care decisions for you that your agent believes to be in your best interest, considering your personal values. If you do not wish to provide specific, written health care instructions in your Advanced Health Care Directive, draw a line through this Section and skip to Section 4.

The following are statements about the use of life-support treatments. Life-support or life-sustaining treatments are any medical procedures, devices or medications used to keep you alive. Life-support or life-sustaining treatments may include medical devices put in you to help you breathe, food and fluid supplied artificially by medical device (IV/feeding tube), cardiopulmonary resuscitation (CPR), major surgery, blood transfusions, kidney dialysis, and antibiotics.

Sign either of the following general statements about life-support or life-sustaining treatments if one accurately reflects your desires. If you wish to modify or add to either statement or to write your own statement instead, you may do so on a separate sheet(s) of paper (one lined, separate sheet is included in this Kit). You must date, sign, and attach any additional pages to this Directive. If you have a serious medical condition or terminal illness and have identified your specific health care wishes in a fully executed POLST form signed by your physician, you may initial the last option indicating such.

OPTIONAL: If I am suffering from a terminal condition from which death is expected in a matter of months, or if I am suffering from an irreversible condition that renders me unable to make decisions for myself, and life-support or life-sustaining treatments are needed to keep me alive, then:

A. I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and that my physician(s) allows me to die as gently as possible. I understand and authorize this statement as proved by my signature here:

_____

OR

B. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. I understand and authorize this statement as proved by my signature here:

_____

OPTIONAL: I have attached _____ page(s) of specific health care instructions to this Directive, each of which is signed and dated on the same day I signed this Directive.

OPTIONAL: I have a fully executed POLST dated _____ that identifies my specific health care wishes as indicated by my initials here: _____

4. ORGAN AND TISSUE DONATION

☐ **I wish to be an organ and tissue donor*.**

☐ **After organ and/or tissue donation or if organ and/or tissue donation is not possible, I give my body.**

☐ **I have contacted and made arrangements with a hospital, accredited medical school, dental school, college, or university.**

Name of Institution:_____

☐ **I have registered my decision to be a donor with Donate Life California Organ and Tissue Donor Registry or through the DMV.**

(Note: Only donor designations indicated on identification cards and driver licenses (ID/DLs) issued after July 2006 have been added to the Donate Life California Registry. All donors with ID/DLs issued prior to this date must register their decision online at www.donateLIFEcalifornia.org or at their next ID/DL renewal.)

I understand and authorize this statement as to organ and tissue (and body) donation as proved by my signature here:

_____

* Be sure to communicate your donation intentions to your family members, loved ones, and physician(s). For more information on organ and tissue donation or to designate limitations on your donated gift, please contact Donate Life California at 866-797-2366 or at info@donatelifecalifornia.org.

5. DATE AND SIGNATURE OF PRINCIPAL

As the Principal, you must sign and date this Advance Health Care Directive or instruct another person to sign it for you in your presence. As Principal, if you are mentally capable but physically unable to sign, any mark you make with the full intention of designating your signature is acceptable. Your name and the name of any person signing for you must be printed and signed and two qualified witnesses must complete the Statement of Witnesses in Section 6a.

A copy of this completed form has the same effect as the original.

I sign my name to, place my mark on or have instructed the person identified below to sign for me in my presence, and I acknowledge this Advance Health Care Directive:

_____

Print name of Principal (and if any, name of adult signing in Principal's presence at Principal's direction)

_____

Signature (or mark) of Principal (or signature of adult, if any, signing in Principal's presence at Principal's direction)

_____

(Date Signed)

6. AUTHENTICATION BY WITNESSES OR NOTARY

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.

Special Rules for Skilled Nursing Facility Residents

If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman: (1) sign as a witness; and (2) sign the Statement of Patient Advocate or Ombudsman that follows. You must also have a second qualified witness sign this Directive or have this document acknowledged before a notary public.

6a. 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 Health Care 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 Health Care Directive; and (5) that I am not the individual's health care provider nor an employee of that health care provider, nor an operator or employee of an operator of a community care facility or a residential care facility for the elderly.

FIRST WITNESS:

Print Name: _____

Signature: _____

Date: _____ Residence Address: _____

SECOND WITNESS:

Print Name: _____

Signature: _____

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 by blood, marriage, or adoption to the individual executing this Advance Health Care Directive, 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: _____ Date: _____

FOR SKILLED NURSING FACILITIES: STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign the Statement of Witnesses above, and must also sign the following declaration:

I further 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 am serving as a witness as required by Probate Code 4675.

Print Name/Title: _____

Address: _____

Signature: _____ Date: _____

6b. CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

Acknowledgment before a notary public is not required if two qualified witnesses have signed this Directive in Section 6a. If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign the Statement of Witnesses and the Statement of Patient Advocate or Ombudsman in Section 6a, even if you also have this form notarized.

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.

State of California)

County of _____,)

On _____,

(Date)

before me, _____,

personally appeared _____,

(Name and title of Notary Officer)

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 signatures(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 _____ **(Seal)**

*EVIDENCE OF IDENTITY: *The following forms of identification are satisfactory evidence of identity: a California driver's license or identification card or U.S. passport that is current or has been issued within five years, or any of the following if the document is current or has been issued within 5 years, contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number: a foreign passport that has been stamped by the U.S. Immigration and Naturalization Service; a driver's license issued by another state or by an authorized Canadian or Mexican agency; an identification card issued by another state or by any branch of the U.S. armed forces, or for an inmate in custody, an inmate identification card issued by the Department of Corrections. If the principal is a patient in a skilled nursing facility, a patient advocate or ombudsman may rely on the representations of family members or the administrator or staff of the facility as convincing evidence of identity if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal and may serve as a witness for notary under specified circumstances if the witness is personally known to the officer.*

Additional forms can be purchased from: CMA Publications, 1201 J Street, Suite 375, Sacramento, CA 95814-2905 Phone: 800-882-1262 • Fax: 916-551-2035 • Website: www.cmanet.org.

Attachment 1 of _____.

HEALTH CARE INSTRUCTIONS

OPTIONAL: Other or additional statements of medical treatment desires and limitations:

Signature: _____ **Date:** _____