FORM 3-1

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form 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 an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, 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. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

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. You also can add to the choices you have made or write down 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.

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

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)* *(cell/pager)*

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 first alternate agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

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:

Name of individual you choos

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)

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)

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)*

Research _____ *(Initial here)*

Therapy _____ *(Initial here)*

Education _____ *(Initial here)*

PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician: _____ Telephone: _____

Address: _____

_____

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: _____ Telephone: _____

Address: _____

_____

PART 5 – SIGNATURE

The form must be signed by two qualified witnesses, or acknowledged before a notary public.

***SIGNATURE*:** Sign and date the form here:

Date: _____

Name: _____ _____
(sign your name) *(print your name)*

Address: _____

_____

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: _____ Telephone: _____

Address: _____

_____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Name: _____ Telephone: _____

Address: _____

_____

Signature of Witness: _____ Date: _____

ADDITIONAL STATEMENT OF WITNESSES: 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 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 of Witness: _____

Signature of Witness: _____

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

State of California }
} SS.
County of _____ }

On *(date)*