***ADVANCE HEALTH CARE DIRECTIVE***

***PART 1***

***POWER OF ATTORNEY FOR HEALTH CARE***

1. DESIGNATION OF AGENT. I designate the following individual as my agent to make health-care decisions for me:

**Agent:**

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

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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_ \_\_\_\_\_\_\_\_\_\_

Phone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

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 initial the following line.

\_\_\_\_ If I initial this line, my agent's authority to make health-care decisions for me takes effect immediately.

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 give 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.

5. NOMINATION OF GUARDIAN OR CONSERVATOR. If a guardian or conservator of my person or estate or both, 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 guardian or conservator, I nominate the alternate agents whom I have named, in the order designated.

***PART 2***

***INSTRUCTIONS FOR HEALTH CARE***

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 this part of the form.

6. 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 initialed below:

\_\_\_\_ CHOICE TO PROLONG LIFE. I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

7. ARTIFICIAL NUTRITION AND HYDRATION. Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph 6 unless I initial the following line.

\_\_\_\_ If I initial this line, artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph 6

8. RELIEF FROM PAIN. I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

***PART 3***

***DONATION OF ORGANS AT DEATH***

9. Upon my death, I give any needed organs, tissues or parts.

My gift is for the following purposes: transplantation

***PART 4***

***PRIMARY PHYSICIAN***

10. I designate the following physician as my primary physician:

**Physician:**

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

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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_ \_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PART 5***

11. EFFECT OF COPY. A copy of this form has the same effect as the original.

12. SIGNATURE.

**Declarant Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

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

NOTICE: SPECIAL RULES APPLY IF YOU ARE A RESIDENT OF A SKILLED NURSING FACILITY. IF YOU RESIDE IN SUCH A FACILITY, THIS DOCUMENT MUST BE SIGNED BY A PATIENT ADVOCATE OR OMBUDSMAN. IF YOUR DOCUMENT IS BEING WITNESSED BY TWO WITNESSES, ONE OF THOSE WITNESSES MUST BE THE ADVOCATE OR OMBUDSMAN WHO SIGNS ALL WITNESS STATEMENTS. IF YOUR DOCUMENT IS BEING NOTARIZED, THE ADVOCATE OR OMBUDSMAN MUST SIGN THE SPECIAL WITNESS REQUIREMENT SECTION.

13. STATEMENT OF WITNESSES: [If you are a resident in a skilled nursing facility, a patient advocate or ombudsman must sign this statement as one of your two witnesses.]

I declare under penalty of perjury under the laws of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

(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,

(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, and

(6) that I am an adult.

**Witness Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Witness Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

14. ADDITIONAL STATEMENT OF ONE OF THE ABOVE WITNESSES. [If you are a resident in a skilled nursing facility, the patient advocate or ombudsman must sign this statement.]

I further declare under penalty of perjury under the laws of \_\_\_\_\_\_\_\_\_\_ 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.

**Witness Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

15. SPECIAL WITNESS REQUIREMENT.

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 \_\_\_\_\_\_\_\_\_\_ that I am a patient advocate or ombudsman as designated by state code.

**Witness Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_