

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

EXPLANATION

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.

Part 1 of this form is a power of attorney for health care. 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:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.
- (c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- (e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

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. Space is also provided for you to add to the choices you have made or for you to 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 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form contains all signatures, including witness signatures, required to execute this document.

After completing this form, sign and date the form at the end. 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. This document has been tailored to the COVID-19 crisis.

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:

FIRST SELECTION:

TELEPHONE:

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:

SECOND SELECTION:

TELEPHONE:

(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, blood transfusions, antibiotics, pain management, and all other forms of health care to keep me alive.

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when I am admitted to a medical facility and unable to make my own health care decisions.

(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 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.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains.

(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:

(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. I request a ventilator in the event it is needed to treat COVID-19.

(2.2) RELIEF FROM PAIN: I direct that treatment for alleviation of pain or discomfort be provided at all times, including but not limited decisions to provide, withhold, or withdraw artificial nutrition and hydration, blood transfusions, antibiotics, pain management, and all other forms of health care to keep me alive even if it hastens my death.

(2.3) OTHER WISHES I direct that: In the event I am unable to breath, I am requesting ventilator assistance and any other means necessary to keep me alive.

(2.4) CLINICAL TRIALS: I direct that my health care providers and others involved in my care adhere to my decisions regarding COVID-19 treatment:

I CONSENT to being part of a clinical trial.

I **DO NOT** CONSENT to being part of a clinical trial.

(2.5) EXPERIMENTAL DRUGS: I direct that my health care providers and others involved in my care adhere to my decisions regarding COVID-19 treatment:

I CONSENT to the use of experimental drugs.

I **DO NOT** CONSENT to the use of experimental drugs.

PART 3: DONATION OF ORGANS AT DEATH

(3.1) DONATION OF ORGANS: 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: SIGNATURES

(4.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(4.2) SIGNATURE: Sign and date the form here:

_____	_____
(date)	(sign your name)
_____	_____
(address)	(print your name)
_____	_____
(city)	(state)

(3.3) 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

Second Witness

(print name)

(print name)

(address)

(address)

(city) (state)

(city) (state)

(signature of witness)

(signature of witness)

(date)

(date)

(3.4) 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.

(print name)

(signature of witness)