

California maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at <http://www.sos.ca.gov/ahcdr/forms.htm>.

INSTRUCTIONS FOR YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

How Do I make my advance health care directive legal?

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself.

Your signature must be witnessed by or you must acknowledge your signature before a notary public or two adult witnesses. Your two adult witnesses may not be

- your health care provider or an employee of your health care provider,
- the operator or an employee of a community care facility,
- the operator or an employee of a residential care facility for the elderly, or
- the person you have appointed as an agent, if you have appointed an agent.

In addition, one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate.

If you are a patient in a skilled nursing facility when you execute your advance directive, one of your witnesses must be a patient advocate or ombudsman.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

Your agent cannot be

- your supervising health care provider,
- the operator of a community care facility or residential care facility where you are receiving care, or
- the employee of a health care institution where you are receiving care or employee of a community care facility or residential care facility where you are receiving care, unless:
 - o the employee is related to you by blood, marriage, or adoption,
 - o the employee is your registered domestic partner, or
 - o the employee is your coworker at the facility or institution.

If you have a conservator appointed for you as part of involuntary commitment proceedings under the Lanterman-Petris-Short Act, that conservator cannot be appointed as your agent unless you are represented by a lawyer who signs a certificate stating that you have been advised of your rights. If this applies to you, you should talk with your lawyer about your rights, the applicable law, and the potential consequences involved.

On the other hand, you may include in your advance directive a nomination for the individual appointed as your conservator, if necessary. The court will consider your nomination in any protective proceeding.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling or unavailable to act for you.

Should I add personal instructions to my advance directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future health care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

Except for the appointment of your agent, you may revoke any portion or this entire advance directive at any time and in any way that communicates your intent to revoke. This could be by telling your agent or physician that you revoke, by signing a revocation, or simply by tearing up your advance directive.

In order to revoke your agent's appointment, you must either tell your supervising health care provider of your intent to revoke or revoke your agent's appointment in a signed writing.

If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

Unless you specify otherwise in Part 2, if you designate your spouse as your agent, that designation will automatically be revoked by divorce or annulment of your marriage.

What other important facts should I know?

Your agent, if you appoint one, does not have authority to authorize convulsive treatment, psychosurgery, sterilization, or abortion, or to have you committed or placed in a mental health treatment facility.

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

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 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 an employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a co-worker. Your supervising health care provider can never act as your agent.)

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; and
- (e) Make anatomical gifts, authorize an autopsy, and direct the disposition of your 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 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 lets you designate a physician to have primary responsibility for your health care.

Part 5 After completing this form, sign and date the form in. 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 and alternate agent(s) 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**

CALIFORNIA 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:

(Name of individual I choose as agent)

Address	City	State	Zip
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Home Phone	Mobile Phone	eMail
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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 I choose as agent)

Address	City	State	Zip
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Home Phone	Mobile Phone	eMail
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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 I choose as agent)

Address	City	State	Zip
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Home Phone	Mobile Phone	eMail
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CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

(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:**

(3) WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE: (Check one Box)

, 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**.

(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) AGENT’S POST-DEATH AUTHORITY:

My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here, in paragraph (2) above, or in Part 3 of this form:

(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.

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

PART 2: INSTRUCTIONS FOR HEALTHCARE

If you fill out this part of the form, **you may strike any wording you do not want.**

(7) 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: **(Initial only one box)**

(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.

(8) RELIEF FROM PAIN

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

(9) 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.)

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

**PART 3: DONATION OF ORGANS AT DEATH
(OPTIONAL)**

(10) Upon my death: (initial applicable box)

- (a) I do not give any of my organs, tissues, or parts and do not want my agent, conservator, or family to make a donation on my behalf,
- (b) I give any needed organs, tissues, or parts, OR
- (c) I give the following organs, tissues, or parts only:

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)**

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

(Name of Physician)

Address	City	State	Zip
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Work Phone	Mobile Phone	eMail
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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)

Address	City	State	Zip
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Work Phone	Mobile Phone	eMail
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(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

PART 5: EXECUTION

This Health Care Directive will not be valid unless it is **EITHER:**

- (A) Signed by two (2) qualified adult witnesses who are personally known to you or to whom you have proven your identity by convincing evidence and who are present when you sign or acknowledge your signature. **Your witnesses may not be**
- your health care provider or an employee of your health care provider,
 - the operator or an employee of a community care facility,
 - the operator or an employee of a residential care facility for the elderly, or
 - the person you have appointed as an agent, if you have appointed an agent.

In addition, **one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate.**

(Use Alternative 1, below, if you decide to have your signature witnessed.)

OR

- (B) Witnessed by a notary.

(Use Alternative 2, below (page 12), if you decide to have your signature notarized.)

If you are a patient in a skilled nursing facility when you execute your advance directive, one of your witnesses must be a patient advocate or ombudsman. This witness must sign the statement on page 13, even if you have had your advance directive notarized.

OPTION 1: Sign before a Witness

_____ (Your Printed Name)		_____ (Your Signature)		_____ (Date)			
_____ Address		_____ City		_____ State		_____ Zip	
_____ Home Phone		_____ Mobile Phone		_____ eMail			

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 an 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.

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

First Witness:

(Printed Name)	(Signature)	(Date)	
<hr/>			
Address	City	State	Zip
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Home Phone	Mobile Phone	eMail	

Second Witness:

(Printed Name)	(Signature)	(Date)	
<hr/>			
Address	City	State	Zip
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Home Phone	Mobile Phone	eMail	

ADDITIONAL WITNESS STATEMENT

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.

First Witness:

(Printed Name)	(Signature)	(Date)
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ADDITIONAL WITNESS STATEMENT

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.

Second Witness:

(Printed Name)	(Signature)	(Date)
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CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

ALTERNATIVE NO. 2: NOTARY PUBLIC

(Your Printed Name)	(Your Signature)	(Date)	
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Address	City	State	Zip
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Home Phone	Mobile Phone	eMail	

State of California

County of _____)

On _____ before me, _____
(insert name of notary public)

personally appeared _____
(insert the name of principal)

Who proved to me on the basis of satisfactory evidence to be the person(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 signature(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 of Notary

NOTARY SEAL

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

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 witness as required by section 4675 of the Probate Code.

(Printed Name) (Signature) (Date)

Address City State Zip

(Name of Skilled Nursing Facility)

Address City State Zip

You Have Filled Out Your Health Care Directive, Now What?

1. Your California Advance Health Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. California maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at <http://www.sos.ca.gov/ahcdr/forms.htm>.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
7. Remember, you can always revoke your California document.
8. Be aware that your California document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.