Additional forms can be purchased from: 10 copies for $25.00 or 25 copies $50.00
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Phone: 1-800-882-1CMA ·Fax: (415) 882-5195 ·Internet: www.cmanet.org

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 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). 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. Internet access is available at your local public library.

1. APPOINTMENT OF HEALTH CARE AGENT

Option 1. I,_____, wish to appoint a health care agent.
(Print your full name and date of birth)

Fill in below the name and contact information of the person(s) (your agent and alternate agent(s)) you wish to make health care decisions for you if you are unable to make them for yourself. You may appoint alternate agents in case your first appointed agent is not willing, able or reasonably available to make these decisions when asked to do so.
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 institute 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 give that person a copy of this form.
You should make sure that this person understands your wishes and this responsibility and is willing to accept it.

OR

Option 2. I,_____, do not wish to appoint an agent at this time.
(Print your full name and date of birth)

If you choose not to name an agent, initial the box above, print your name on the line in the space provided, draw a line through the rest of this page, then continue to Section 3.

I hereby appoint as my agent to make health care decisions for me:
Name_____*(agent's name)*
Address_____
(street address, city, state, zip code)
Home phone( )_____Work phone( )_____
Cell phone/Pager( )_____Fax( )_____ e-mail_____

I understand this appointment will continue unless I revoke it as explained in Section 5.
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) to do so, listed in the order they should be asked:

OPTIONAL: 1st alternate agent: Name_____e-mail_____

Address_____Home phone( )_____
(street address, city, state, zip code)
Work phone( )_____Cell phone/Pager( )_____Fax( )_____

OPTIONAL: 2nd alternate agent: Name_____e-mail_____

Address_____Home home( )_____
(street address, city, zip code)
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 desires. ***It is important that you discuss your health care desires with the person(s) you appoint as your health care agent, 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.*

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 care 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.

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, 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.

OPTIONAL: I want my agent agent's authority t make health care decisions for me to start now, **even though I am still able to make them for myself.** I understand and authorize this statement as proved by my Signature_____.

3. HEALTH CARE INTRUCTIONS

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, draw a line through this Section.***

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 treatments may include: medical devices put in you to kelp you breathe; food and fluid supplied artificially by medical device (feeding tube); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; kidney dialysis; and antibiotics.

Sign either of the following general statements about life-support 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 in the space provided or on a separate sheet(s) of paper which you must date and sign and attach t this form.

OPTIONAL: The statement I have signed below is to apply 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 treatments are needed to keep me alive.

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

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_____.

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

For additional Advance Health Care Directives options, go to the California Medical Association's website at www.cmanet.org.

OPTIONAL: I have added_____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.

4. ORGAN AND TISSUE DONATION

I wish to be an organ donor. I understand and authorize this statement as proved by my signature_____.

I have indicated this on □ my driver's license and/or □ an attached page.

If you do not wish to be an organ donor, draw a line through this Section 4 and initial it.

For additional information concerning organ and tissue donation, go to the California Medical Association website at www.cmanet.org.

5. PRIOR DIRECTIVES REVOKED

I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration.

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 you revoke a prior directive, notify every person, physician, hospital, clinic, or care facility that has a copy of your prior directive and give them a copy of your new directive, if you execute one.

6. DATE AND SIGNATURE OF PRINCIPAL

I sign my name to and acknowledge this Advance Health Directive:

_____

(signature of principal) *(date of birth)* *(date of signing)*

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7. STATEMENT OF WITNESSES

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) acknowledge before a notary public in California. If you use witnesses rather than a notary public, ***the law prohibits using the following as witness: (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 sign as a witness and sign the statement of Patient Advocate or Ombudsman. (See following page.) You must also have a second qualified witness sign below or have this document acknowledged before a notary public.

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 (*see nest page), (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) 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:_____

(date) *(name printed)* *(signature)*

Residence Address:_____

Second Witness:_____

(date) *(name printed)* *(signature)*

Residence Address:_____

AT LEAST ONE OF THE ABOVE WITNESSES MSUT 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 operating of law.

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ADVANCE DIRECTIVES ACKNOWLEDGEMENTS

PLEASE READ THE FOLLOWING STATEMENTS

1. I have been given written materials about my rights to accept or refuse medical treatment.

2. I have been informed of my rights to formulate an Advance Directive.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment.

4. I understand the terms of my Advance Directive will be followed by the hospital, to the extent permitted by law, should I become unable to communicate my wishes.

5. I understand it is my responsibility to provide the facility with a copy of my Advance Directive, and in the absence of my actual Advance Directive, I will receive life-sustained procedures and treatment unless otherwise documented.

Patient Signature_____Date/Time_____

Witness:_____Date/Time_____