CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE
AND HEALTH CARE INSTRUCTION FORM

NOTE: COMPLETION OF THIS FORM IS ONLY THE FIRST STEP.
YOU SHOULD DISCUSS YOUR WISHES IN DETAIL WITH YOUR DESIGNATED AGENT(S).

- WITH THIS FORM YOU MAY DO ANY OR ALL OF THE FOLLOWING:
  1. NAME AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT.
  2. INSTRUCT DOCTORS AND OTHER HEALTH CARE PROFESSIONALS HOW YOU WOULD LIKE TO BE TREATED IF YOU ARE HURT OR SERIOUSLY ILL AND UNABLE TO TELL THEM YOUR WISHES.
- READ THE FORM CAREFULLY. CROSS OUT ANY PROVISION YOU DO NOT WANT.
- THIS FORM REVOKES ANY PRIOR DIRECTIVES YOU HAVE MADE.
- AFTER YOU COMPLETE THIS FORM SIGN AND DATE IT. TWO WITNESSES OR A NOTARY MUST ALSO SIGN AND DATE IT.

My name is: _____.

In this document I appoint an agent. That agent will make health care decisions for me in the future, if and when I no longer have the mental capacity to make my own health care decisions. My primary care physician will determine when I am unable to make health care decisions for myself.

Part 1 - NAMING YOUR AGENT (If you do not have an agent, please proceed to Part 2 on page 3)

The following persons cannotbe selected as your agent or alternate agent:
- *Your primary physician.*
- *An employee of the health care institution or residential care facility where you receive care (unless you are related to that person).*

AGENT

Name: _____

Address: _____
City *State* *Zip*

Home Phone: (____) _____ Work Phone: (____) _____

1ST ALTERNATE AGENT (If Agent is unavailable or unwilling to serve.)

Name: _____

Address: _____
City *State* *Zip*

Home Phone: (____) _____ Work Phone: (____) _____

2ND ALTERNATE AGENT (If Agent and 1ST Alternate Agent are unavailable or unwilling to serve.)

Name: _____

Address: _____
City *State* *Zip*

Home Phone: (_____) _____ Work Phone: (_____) _____

AGENT'S AUTHORITY

Except as limited by this document, my agent will have authority to make health care decisions for me to the extent that I now have authority to make my own health care decisions. This authority includes, but is not limited to, the authority 1) to accept or refuse treatment, nutrition and hydration, 2) to choose a particular physician or health care facility, and 3) to receive, or consent to the release of, medical information and records.

Also, except as limited by this document, this authority includes the authority to authorize an autopsy, donate all or part of my body, and/or determine the disposition of my remains. The agent's actions must be consistent with my will or trust, and with any funeral arrangements or other arrangements which I have made. (Cross this out if you do not wish your agent to have this authority.)

AGENT'S AUTHORITY UNDER HIPAA & CMIA

My agent shall be my personal representative under HIPAA and CMIA and shall have the same rights to inspect, obtain and disclose my protected health information as I have.

I make the following instructions to my agent:

I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of treatment outweigh the expected benefits. In making decisions about life sustaining treatment under (3) above, I want my agent to consider the relief of suffering and the quality of my life as well as the extent of the possible prolongation of my life.

If this statement reflects your desires, initial here: _____

Other health care instruction to my agent: _____

_____

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. (Cross out if not desired.)

AGENT'S OBLIGATIONS

1. My agent shall make decisions for me in accordance with this power of attorney, other instructions I make in this form and my personal wishes, to the extent my agent knows them. If my wishes on a subject are not known, the agent shall make decisions consistent with my best interest, taking into account my personal values to the extent they are known to my agent.

2. My agent shall provide a copy of this advance health care directive to any health care provider or facility that takes on responsibility for my care.

Part 2 - HEALTH CARE IN STRUCTI ONS (For individuals without an agent or for when no agent is available.)

If I am in an irreversible coma or persistent vegetative state; or if I am terminally ill and the provision of life sustaining procedures would serve to artificially delay the moment of my death; then, I make the following instruction, by placing my signature in front of my request:

_____ I authorize all treatments to prolong my life for as long as possible.

_____ I authorize the treatment needed to provide me with food, water, and pain control, and to keep me comfortable, but otherwise do not authorize active treatment for my medical conditions.

_____ I authorize the treatment needed to provide me with pain control and to keep me comfortable, but do not authorize the provision of food or water through a tube or an intravenous line, and do not authorize active treatment for my medical conditions.

Other health care instructions: _____

_____

_____

REVOCATION OF PREVIOUS DOCUMENTS

I revoke any previously executed Power of Attorney for Health Care, Individual Health Care Instruction, or Natural Death Act Declaration.

SIGNATURE OF PRINCIPAL (Sign and date form here in front of witnesses or a notary.)

Date: _____ Signature: _____

(If principal is not physically able to sign, he or she can instruct another person to sign the principal's name, if signature is done in the principal's presence.)

STATEMENT OF WITNESSES

This document must either be notarized, or signed by two witnesses. If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a representative of California's Long-Term Care Ombudsman Program. If the two-witness method is chosen, the Ombudsman Program representative may serve as one of the two witnesses, or may serve as a third witness. If the notarization method is chosen, the Ombudsman Program representative serves as a separate witness. Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements.

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 (printed) *Signature*

Date: _____ Address: _____
City *State* *Zip*

Second Witness: _____ _____
Name (printed) *Signature*

Date: _____ Address: _____
City *State* *Zip*

ONE OF THE PRECEDING WITNESSES ALSO MUST 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.

Date: _____ Signature: _____

DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE
(Required if person appointing the agent currently resides in a nursing facility.)

I declare under penalty of perjury under the laws of California that I am an ombudsman designated by the California Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Date: _____ Signature: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC (Not required if two-witness method is followed.)

State of California, County of _____

On _____ before me, (name and title of officer) _____,

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(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 _____

NOTE: USE OF THIS FORM IS NOT APPROPRIATE FOR EVERY PERSON OR EVERY SITUATION.
FOR MORE INFORMATION ABOUT POWERS OF ATTORNEY FOR HEALTH CARE, CONSULT WITH AN ATTORNEY.