ADVANCE HEALTHCARE DIRECTIVE

Part 1: Power of Attorney for Healthcare

1. Designation of Agent: I, _____, of _____, California, designate the following individual as my agent ("***Agent***") to make healthcare decisions for me:

Name of Individual You Choose As Agent: _____
Address: _____
Phone: _____

First Alternate Agent: If I revoke my Agent's authority or if my Agent is not willing, able, or reasonably available to make a healthcare decision for me, I designate as my first alternate agent ("***First Alternate Agent***"):

Name of Individual You Choose As First Alternate Agent: _____
Address: _____
Phone: _____

References to "my Agent" shall include the First Alternate Agent when the First Alternate Agent serves as the agent under this Advance Healthcare Directive.

2. Agent's Authority: My Agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of healthcare to keep me alive, except as I state here (if no exceptions, write "none"):

_____

_____

_____

_____

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 healthcare decisions unless I mark the following box. If I initial this box [ ], my agent's authority to make healthcare decisions for me takes effect immediately.

4. Agent's Obligation: My Agent shall make healthcare decisions for me in accordance with this Advance Healthcare Directive, 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 healthcare 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 Postdeath Authority: My Agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form (if no exceptions, write "none"):

_____

_____

6. Nomination of Conservator: If a conservator of my person needs to be appointed for me by a court, I nominate my Agent. If my Agent is not willing, able, or reasonably available to act as conservator, I nominate my First Alternate Agent.

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 healthcare 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.

[ ] (b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards.

8. Relief From Pain: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death (if no exceptions, write "none"):

_____

_____

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. If you have no other wishes, write "none.") I direct that:

_____

_____

Part 3: Donation of Organs at Death

10. Wishes for Organ Donation: Upon my death (mark applicable box):

[ ] (a) I give any needed organs, tissues, or parts.

[ ] (b) I give the following organs, tissues, or parts only:

_____

[ ] (c) My gift is for the following purposes: *[delete any of the following you do not want]*

(1) Transplant

(2) Therapy

(3) Research

(4) Education

Part 4: Primary Physician

11. Designation of Primary Physician: I designate the following physician as my primary physician:

Name of Physician: _____

Address: _____

Phone: _____

Secondary Designation: 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: _____

Phone: _____

Part 5: Signatures

12. Effect of Copy: A copy of this form has the same effect as the original.

13. Signature: Sign and date the form here:

_____
Signature

_____
Print Name

Date: _____

Alternative #1: Witnesses

Statement of Witnesses: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance healthcare 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 healthcare provider, an employee of the individual's healthcare 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

_____
Signature of Witness

_____
Print Name

_____
Address

_____
Date

Second Witness

_____
Signature of Witness

_____
Print Name

_____
Address

_____
Date

Additional Statement of Witnesses: 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 healthcare 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.

_____
Signature of Witness

Alternative #2

Certificate of Acknowledgment of Notary Public

State of California
County of _____

On _____ before me, _____, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by /hisher signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

_____

My commission expires _____

Date: _____