

State of California

POWER OF ATTORNEY FOR HEALTH CARE

California Probate Code Section 4701

1. DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Agent's Full Name

Agent's Address

City

State

Zip Code

Agent's Home phone

Agent's Work Phone

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:

Alternate Agent's Full Name

Alternate Agent's Address

City

State

Zip Code

Alternate Agent's Home Phone

Alternate Agent's Work Phone

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:

Second Alternate Agent's Full Name

Second Alternate Agent's Address

City

State

Zip Code

Second Alternate Agent's Home phone

Second Alternate Agent's Work Phone



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)

- My agent's authority to make health care decisions for me takes effect immediately.
- My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

4. AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care 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:

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.

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

8. SIGNATURE: Sign and date the form here:

Principal's Signature

Date

Principal's Name

Principal's Address

City

State

Zip Code



9. 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

Witness Signature	Date
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Witness Name

Witness Address

City	State	Zip Code
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Second Witness

Witness Signature	Date
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Witness Name

Witness Address

City	State	Zip Code
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10. 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.



Witness Signature

Witness Signature

11. SPECIAL WITNESS REQUIREMENT: The following statement is required only if you are a patient in a skilled nursing facility-a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

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 a witness as required by Section 4675 of the Probate Code.

Special Witness Signature

Date

Special Witness Name

Special Witness Address

City

State

Zip Code



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.

This form 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.

You can also express an intention to donate your bodily organs and tissues following death.

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.

