ADVANCE HEALTHCARE DIRECTIVE

1) **Designation of Healthcare Agent**. I, ____________, of ______________, California, hereby designate and appoint _____________ of _______________, California, telephone number (___) ________, as my agent to make health care decisions authorized in this document.

2) **Designation of Alternate Healthcare Agent**. If the person I designated as my healthcare agent in paragraph 1 is unable or unwilling to act as my agent, or if I revoke that person's appointment as my agent, then I designate the following persons to serve as my agent, in the order listed below, to make healthcare decisions for me, as authorized in this document:

First Alternate Agent   Address/Telephone

____________________   _______________________
____
(___) _________________

Second Alternate Agent   Address/Telephone

____________________   _______________________
____
(___) _________________

3) **Nomination of Conservator of Person**. If it becomes necessary to appoint a conservator of my person, I nominate the following persons in the following order to act as the conservator of my person:

Nominee   Address/Telephone

____
____
(___) _________________

First Alternate Nominee   Address/Telephone

_____________________   _______________________
____
(___) _________________

Second Alternate Nominee   Address/Telephone

______________________   ________________________
                                ____
                                (___) _________________

I grant to my conservator all the powers specified in the California Probate Code. My conservator shall serve in such capacity without bond, or, if a bond is required, I request that a minimum bond be set. I revoke all prior conservatorship nominations.

4) **General Statement of Authority Granted**.

(a) If I become incapable of making informed healthcare decisions, I hereby grant to my agent full power and authority to consent, refuse consent, or withdraw consent to any type of healthcare procedure (including any procedure to maintain, diagnose, or treat any physical or mental condition) or to make any other healthcare decision, to the extent that I could if I had the capacity to do so, subject to the terms of this instrument. My agent shall exercise this power and authority in accordance with my express desires, known to my agent, whether contained in this document or not. Before acting, my agent shall attempt to communicate with me regarding my desires unless such an attempt would be futile. If my desires are unknown, then my agent should decide for me, having my best interests in mind. My agent is further authorized as follows:

(i) To authorize, or refuse to authorize, any healthcare decision, or medical treatment, if I shall be physically or mentally incapacitated or otherwise unable to make such authorization for myself, including but not limited to, authorization for emergency care, hospitalization, surgery, therapy, and/or any other kind of treatment or procedure that, in my agent=s discretion, my agent thinks necessary for my benefit and well being;

(ii) To consult with and advise any physicians, nurses, therapists, dentists, or other medical and/or healthcare institutions on my behalf, as such consultations relate to my health and welfare. All such personnel and institutions are specifically requested to abide by any and all decisions and instructions of my agent

and to release to my agent any and all information that my agent may request concerning my health and well being.

(b) Healthcare decisions include a decision regarding the selection and discharge of healthcare providers and institutions, approval or disapproval of diagnostic tests, surgical procedures, and programs of medication; and directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of healthcare, including cardiopulmonary resuscitation. It means consent, refusal of consent, or withdrawal of consent for any care, treatment, service, or procedure to affect my physical or mental condition, as well as consent to release of medical information.

(c) I trust my agent, who knows and understands my desires, and in whose judgment I have absolute faith, to exercise discretion in a manner that would be satisfactory to me if I had the capacity to give or refuse to give consent.

(d) Before acting, my agent shall attempt to communicate with me regarding my desires unless such attempt would be futile. If I am unreachable by such communication, and my desires regarding a particular healthcare decision are unknown, my agent should make the healthcare decision guided by the following: My personal values, any preferences that I have previously expressed, preferences stated herein, and any information received from attending physicians concerning my prognosis, all the while having my best interests in mind. In determining my best interests, my agent shall consider my personal values to the extent known to my agent.

5) **When Agent′s Authority Becomes Effective**. My agent′s authority shall become effective when two (2) physicians, not related by blood or marriage, determine that I am unable to make my own healthcare decisions.

6) **Instructions for Healthcare**.

First Alternative - Withdrawal of Life Sustaining Equipment

(a) If I am in a coma and have been for at least ______________ (___) days, which two (2) qualified physicians familiar with my condition have diagnosed as irreversible (i.e., there is no reasonable possibility that I will regain consciousness), then I desire that all life sustaining treatment be removed or withheld.

Second Alternative - Prolong Life

(a) I express the desire that my life be prolonged to the greatest possible extent without regard for my physical or mental condition, chance of recovery, likelihood of suffering, or expense, and authorize my agent to consent to whatever medical procedures are necessary to accomplish this end. I trust my agent who knows my desires well, and in whose judgment I have absolute faith, to exercise discretion in a manner that would be satisfactory to me.

Third Alternative - Do Not Prolong Life

(a) If I have an incurable or irreversible physical or mental condition, even if I am not in a persistent vegetative state or some other form of permanent unconsciousness, I want care and treatment that will enable me to take part in activities of daily living, to eat and drink and to communicate meaningfully with others. I want to live my life with dignity and for my loved ones to have pleasant memories of my final days. Thus, I wish to be allowed to die without prolonging my death with medical treatment that will not benefit me.

Fourth Alternative - Option To Not Prolong Life

(a) I wish to make my own decisions as long as I am able to do so. If I am incapacitated, then I give my agent full authority and discretion to make decisions about medical treatment for me within the context of the following personal values:

(i) I want to die a natural death without having my life prolonged my machines or non-beneficial treatment;

(ii) I want my religious beliefs to be honored;

(iii) I want to die free of unnecessary pain and suffering, even if pain medication will shorten my life;

(iv) I do not want to be a burden to my family.

I trust my agent to make my medical decisions within the context of these values.

(b) *First Alternative - Nutrition and Hydration*. Regardless of my condition, it is my desire to receive nutrition and hydration in all ways possible. But if I

am in a coma for ______________ (______) days, my agent is instructed not to continue nutrition and hydration by any artificial means as long as they are not necessary for comfort or alleviation of pain.

(b) *Second Alternative - No Artificial Nutrition Except for Treatment of Temporary Condition*. I do not want artificial nutrition and hydration under any circumstances except for the treatment of a temporary condition in which I am able to eat or drink and then only for a short time. If, within a short period (as determined by my agent after consultation with my physician), there is no benefit to me, then I instruct that all artificial nutrition and hydration be withdrawn.

(b) *Third Alternative - No Artificial Nutrition Except for Comfort or to Alleviate Pain*. I do not want artificial nutrition and hydration unless necessary for my comfort or to alleviate pain.

(c) It is my desire that my agent consent to and arrange for the administration of any kind of pain relief, even though its use, may lead to permanent damage, addition, or even hasten the moment of, but not intentionally cause, my death.

(d) Regarding the decision to withhold or withdraw life sustaining treatment, I desire that my agent act after allowing a reasonable time for observation and diagnosis.

7) **Inspection and Disclosure of Health Information Relating to My Physical or Mental Health**. My agent has the power and authority to do all the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records;

(b) Execute on my behalf, any releases or other documents that may be required in order to obtain this information;

(c) Consent to disclosure of this information.

8) **Signing Documents, Waivers, and Releases**. My agent has the power to execute all necessary instruments and perform all necessary acts required for the execution and implementation of all authorizations contained in this document.

9) **Donations of Organs at Death**.

First Alternative - Any Organs

On my death, my agent is authorized to give any of my organs, tissues or parts. My gift is for the following purposes:

(*Delete any purposes that you do not want*)

(a) Transplants
(b) Therapy
(c) Research
(d) Education

Second Alternative - Specified Organs Only

On my death, my agent is authorized to give any the following organs, tissues or parts only:

(Specify Organs, Tissues or Parts)

My gift is for the following purposes:

(*Delete any purposes that you do not want*)

(a) Transplants
(b) Therapy
(c) Research
(d) Education

Third Alternative - No Organ Donation

On my death, my agent is not authorized to give any of my organs, tissues or parts.

10) **Disposition of Remains**. On my death, my agent is authorized to dispose of my remains as follows:

(Insert Instructions for Burial, Funeral, etc.)

11) **Autopsy**. On my death, my agent (is / is not) granted the power to authorize my autopsy.

12) **Effect of Copy**. A copy of this form shall have the same effect as the original.

IN WITNESS WHEREOF this Advance Healthcare Directive is executed on this ________ day of _________________, 20__, at San Jose, California.

____

Principal

> A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA)
COUNTY OF _________________)

On this ____ day of ______________, 20__ before me, ____________________ ________________________(insert name and title of the officer), personally appeared ___________________________, who 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(ies), and that by his/her signature(s) on the instrument the person or the entity upon behalf of which the person 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) (Seal)