

OPTIONAL: If I revoke (take away) 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:

(print name of second alternate agent)

(relationship to you)

(address)

(city) (state)

(ZIP Code)

(home phone)

(work phone)

(cell phone)



NOTE: You can change who you appoint to be your agent at any time. Also, it is VERY important to inform your agent that you have appointed him/her to be your surrogate decision maker for health care matters. You should discuss your Living Will with your primary and alternate agents to ensure that they understand your values and wishes, and to confirm that they are willing to honor your desires. If they indicate they cannot, you should appoint a different person(s) to be your agent(s).

(1.2) 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:

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when the medical team determines that I am unable to make my own health care decisions unless I mark the following box.

If I initial this box , my agent's authority to make health care decisions for me takes effect immediately.

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

(1.5) 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.

Part 2: INSTRUCTIONS FOR HEALTH CARE

(2.1) END-OF-LIFE DECISIONS: I direct that my health care 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, OR

(b) Choice To Prolong Life

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



NOTE: Physicians have no ethical or legal duty to provide futile medical interventions (even if patients or agents/family demand them). Futile interventions are procedures, services, tests, medications, etc. which are determined to offer you no benefit. Futile interventions can, in fact, be harmful. There are times when dialysis, cardiopulmonary resuscitation (CPR), organ transplant, breathing and feeding tubes, for example, are futile.

(2.2) 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:

(2.3) 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.) I direct that:

(2.4) SPECIFIC VALUE STATEMENTS: below are some statements about how I feel about life, health, health care, dying, and other related matters. I want these statements reflected upon when decisions are being made about my health care. **(You can complete any, all, or none of these with your own written words).**

With regard to serious illness, my life would be no longer worth living if:

I practice the following religious or spiritual beliefs/traditions. This impacts my views about health care and dying as follows:

These are my values about living forever in a nursing home:

These are my values about losing my independence and requiring the assistance of others to take care of me for the rest of my life (e.g., bathing, feeding, personal hygiene):

These are my values about artificial feeding and hydration (feeding tubes):

Theses are my values about a living attached to a breathing machine/ventilator:

These are my values about CPR (cardiopulmonary resuscitation—attempts to revive a stopped heart and/or breathing that has stopped with electric shocks, chest compressions, a breathing tube, medication, etc):

What would you like to say to someone reading this document about your overall attitude toward life?

If possible, I prefer to die at the following location:

At home In a hospital intensive care unit In a nursing home Hospice

Part 3: IMPLANTS

I have the following medical implant devices inside my body (check box):

Pacemaker Defibrillator Pacemaker-Defibrillator combination device
 Ventricular Assist Device Total Artificial Heart

If the medical team writes a Do Not Resuscitate (DNR) Order I want my defibrillator turned off to preserve my comfort.



NOTE: Referring to Section 2.1a of this document, these implants are considered forms of artificial life support which would be turned off with other forms of life support such as dialysis and breathing machines. Also, if you don't have an implant now but receive one in the future, be sure to update your Living Will to reflect this new information (and any change in your values).

Part 4: DONATION OF ORGANS AT DEATH

(4.1) Upon my death (mark applicable box):

- (a) I give any needed organs, tissues, or parts, OR
- (b) I give the following organs, tissues, or parts only:

(list organs, tissues, and/or parts you wish to donate)

- (c) My gift is for the following purposes (circle the ones you want):
- (1) Transplant
 - (2) Therapy
 - (3) Research
 - (4) Education
- d) I do NOT wish to be an organ or tissue donor
- (e) I wish to donate my entire body for research or education (e.g., Willed Body Program)

Part 5: Disposition of my body after death

After my death, I desire my body to be (check one box):

Cremated Buried Other _____

I will will not allow an autopsy of my body. (Check one box)



NOTE: Sometimes, the law requires that an autopsy be performed. If you would like a rabbi or other clergy present, please initial this box:

Part 6: PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

(name of physician)

(address)

(city) (state)

(ZIP Code)

(phone numbers, include pager if available)

YOUR SIGNATURE: Sign and date the form here:

(sign your name)

(date)

(print your name)

(your street address)

(city)

(state)

ZIP

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 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

Second witness

(print name)

(print name)

(address)

(address)

(city) (state)

(city) (state)

(signature of witness)

(signature of witness)

(date)

(date)



NOTE: This form does not have to be notarized but you can have this done if you want. If you are currently hospitalized, please ask your nurse or social worker to arrange for a Notary to come to your bedside. Most hospitals offer this service to their patients.

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.

(signature of witness)

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.

(date)

(sign your name)

(address)

(print your name)

(city) (state) Zip

(phone number)



NOTE: Do not keep this valuable document locked away in your safe deposit box (where few people can access it). Please give a copy to your personal physician, your agent and alternate agent(s), and anyone else you think would benefit from knowing its contents. If you know you have a surgery in the near future, bring a copy of this document to the hospital when you check-in and it will be placed in your medical chart. Some hospitals will even place it on file permanently for safe-keeping. (But if you update your Living Will, be sure to give the hospital and your agent(s) the current version). If you have time, bring it with you when you go to the Emergency Room also. Keep a copy in the glove box of your car. Keep a copy in your purse/briefcase.

******This Living Will pertains to HEALTH CARE only, not personal finances******