PART 1

POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT

I designate the following individual as my agent to make health care decisions for me:

(Name of the individual you choose as your Agent)

(State) (Address) (City) (Zip Code)

(Home Phone) (Work Phone)

DESIGNATION OF ALTERNATE AGENTS (OPTIONAL)

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:

(Name of the individual you choose as your First Alternate Agent)

(Address) (City) (State) (Zip Code)

(Home Phone) (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:

(Name of the individual you choose as your Second Alternate Agent)

(Address) (City) (State) (Zip Code)

(Home Phone) (Work Phone)

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:

(Add additional sheets if needed.)

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

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.

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:

(Add additional sheets if needed.)

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
(If you do fill out this part of the form, you may strike any wording you do not want.)
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 (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness or (iii) 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.

RELIEF FROM PAIN
Except as I state in the following space, I direct treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(Add additional sheets if needed.)

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:

(Add additional sheets if needed.)

PART 3

DONATION OF ORGANS AT DEATH (OPTIONAL)
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
(c) My gift is for the following purposes (strike any of the following you do not want)
(i) Transplant, (ii) Therapy, (iii) Research, (iv) Education

PART 4

DESIGNATION OF PRIMARY PHYSICIAN(S) (OPTIONAL)
I designate the following physician as my primary physician:

(Name of Physician)

(Zip (Address) (City) (State) Code)

(Phone)

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) (City) (State) (Zip Code)

(Phone)

OTHER PROVISIONS

I revoke any prior Advance Health Care Directive.

This Advance Health Care Directive is intended to be valid in any jurisdiction in which it is presented.

This Advance Health Care Directive shall become effective upon my disability or incapacity, unless I have checked the appropriate box in part 1, in which case, my agent's authority becomes effective immediately.

Photocopies of this Advance Health Care Directive may be relied upon as though they were the original.

SIGNATURE OF PRINCIPAL

(Sign and date the form here)

(Date)	(SignYour Name)
(Address)	(Print Your Name
(City)(State)(Zip Code)	(Social Security Number)

SIGNATURES OF WITNESSES OR NOTARY

(This power of attorney will not be valid for making health care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or(b) acknowledged before a notary public in the state.)

ALTERNATIVE NO. 1

WITNESS STATEMENT

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	Second Witness
(Print Name)	(Print Name)
(Address)	(Address)
(City)(State)	(City)(State)
(Signature of Witness)	(Signature of Witness)
(Date)	(Date)

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) (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, City, State) (Print Your Name)

ALTERNATIVE NO. 2

NOTARY PUBLIC

State of California)

)ss.

County of _____)

On this _____ Day of _____ , in the year 20 _____

Before me _____

(insert name and title of officer)

Personally appeared _____

(insert name of principle)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged to me that he or she executed the same in his or her authorized capacity, and that by his or her signature on the instrument the person executed the instrument.

WITNESS my hand and official seal.

(Signature of Notary Public) NOTARY SEAL

A SUMMARY STATEMENT OF HEALTH
CARE POLICIES REGARDING PATIENTS'
RIGHTS OF SELF-DETERMINATION

(Since a summary like this cannot answer all possible questions or cover every circumstance, you should discuss any remaining questions with a representative of this health care facility.)

1. Prior to the start of any procedure or treatment, the physician shall provide the patient with whatever information is necessary for the patient to make an informed judgment about whether the patient does or does not want the procedure or treatment performed. Except in an emergency, the information provided to the patient to obtain the patient's consent shall include, but not necessarily be limited to, the intended procedure or treatment, the potential risks, and the probable length of disability. Whenever significant alternatives of care or treatment exist, or when the patient requests information concerning alternatives, the patient shall be given such information. The patient shall have the right to know the person responsible for all procedures and treatments.

2. The patient may refuse medical treatment to the extent permitted by law. If the patient refuses treatment, the patient will be informed of significant medical consequences that may result from such action.

3. The patient will receive written information concerning his or her individual rights under state law to make decisions concerning medical care.

4. The patient will be given information and the opportunity to make advance directives - - including, but not limited to, a California Instructions for Health Care and/or a Power of Attorney for Health Care.

5. The patient shall receive care regardless of whether or not the patient has or has not made an advance directive.

6. The patient shall have his or her advance directive(s), if any has been created, made a part of his or her permanent medical record.

7. The patient shall have all of the terms of his or her advance directive(s) complied with by the health care facility and caregivers to the extent required or allowed by law.

8. The patient shall be transferred to another doctor or health care facility if his or her doctor(s), or agent of his or her doctor(s), or the health care facility cannot respect the patient's advance directive requests as a matter of "conscience."

9. The patient shall receive the name, phone number and address of the appropriate state agency responsible for receiving questions and complaints about these advance directive policies.