Advance Directive – CALIFORNIA

Name: _____ Date of Birth: ____/____/____

Telephone numbers: (home) _____; (cell) _____

Address: _____

Email: _____

Complete at least **ONE** option from **Step 1** and **Step 2** and complete **Step 3**

Step 1: Choose a health care agent.

CHOOSE **ONE** OR **TWO** BOXES

☐ I choose _____; Relationship _____
(phone number - -) and/or (email_____) as my primary health care agent to speak for me in making health care decisions if I become unable to speak for myself.

☐ I choose _____; Relationship _____
(phone number - -) and/or (email_____) as my secondary health care agent who can speak for me in making health care decisions if I become unable to speak for myself and my primary health care agent is unable to serve.

Step 2: Provide guidance to my health care agent & doctors.

In working together to make treatment decisions and plans for my care, please consider my general preferences described below:

CHOOSE **ONE** BOX ONLY

☐ I am not sure at this time which statements below I most agree with. I trust my health care agent to do what is best for me.

☐ I want to continue living even if my quality of life seems low to others and I am unable to communicate with people. In general, I would accept support of my breathing, heart, and kidney function by machines that require me to be in a hospital or special care unit.

☐ Life is precious, but I understand that we all die sometime. I want to live as long as I can interact with others and can enjoy some quality of life. I would accept intensive treatments only if I had a reasonable chance of getting better. I would refuse long-term support by intensive medications or machines if my quality of life was poor and I was not able to communicate with people.

☐ It is most important to me to avoid suffering. I do not want extraordinary medical treatments, such as breathing machines or cardiopulmonary resuscitation (CPR). If my natural body functions fail, I would refuse treatments and choose to die naturally.

Is there anything your doctors should know about you to provide you with the best care possible?

_____

_____

Step 3: Complete and sign the form in front of EITHER 1) two witnesses OR 2) notary public

Signature _____ Date:_____

Address: _____

1. Option 1 – TWO Witnesses

STATEMENT OF FIRST WITNESS

I declare under penalty of perjury under the laws of California that:

- I was present when the Individual signed this form
- I am at least 18 years old and am not the agent designated in Step 1
- 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,
- the individual signed or acknowledged this advance directive in my presence,
- the individual appears to be of sound mind and under no duress, fraud, or undue influence,
- I am not a person appointed as agent by this advance directive,
- 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.
- 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, and
- I am not entitled to any part of the individual's estate upon her or his death under a will now existing or by operation of law.

Signature:_____

Print Name:_____

Address:_____

Date: _____

STATEMENT OF SECOND WITNESS

I declare under penalty of perjury under the laws of California that:

- I am at least 18 years old and am not the agent designated in Step 1
- 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,
- the individual signed or acknowledged this advance directive in my presence,
- the individual appears to be of sound mind and under no duress, fraud, or undue influence,
- I am not a person appointed as agent by this advance directive,
- 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.
- I was present when the Individual signed this form

Signature:_____

Print Name:_____

Address:_____

Date: _____

Name: _____ Date of Birth: _____

2. Option 2 – Notary

State of California

County of _____

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.

I certify that I know or have satisfactory evidence that _____ signed this instrument and acknowledged if to be his or her free and voluntary art for the uses and purposes mentioned in the instrument

(Notary Seal)

Date: _____

Signature of Notary Public: _____

Printed Name:_____

My Appointment Expires: _____

For California skilled nursing facility residents ONLY

Give this form to your nursing home director ONLY if you live in a nursing home. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

STATEMENT OF THE 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."

Signature	Date		
Print Name			
Street Address	City,	State	Zip Code

Name: _____ Date of Birth: _____

Instructions for Step 1: Appointing a health care agent.

Name someone you trust to make health care choices for you if you are unable to make your own decisions. Provide name and contact information for this person, along with one additional individual

Choose a family member or friend who:

- Is 18 or older and knows you well
- Is willing to do this for you
- Is able to make difficult decisions based on your wishes
- Will effectively communicate the information you provide in this packet to health

Your representative cannot be your doctor or someone who works at the hospital or clinic where you are receiving care unless he or she is a member of your family.

Your health care representative can:

- Decide where you will receive care
- Select or dismiss health care providers
- Say yes/no to medications, tests, treatments
- Take legal action to carry out your wishes

Your health care representative CANNOT authorize:

- Civil commitment
- Electro-convulsive therapy
- Psycho-surgery
- Sterilization
- Abortion

Instructions for Step 2: Information for my health care agent & doctors in making decisions for my care.

Indicate your health care wishes

1. Select one of the choices to provide guidance concerning life support treatments. Below is some information about some life support treatments that may or may not be successful in helping you live longer.

   CPR or cardiopulmonary resuscitation: This may involve (1) Pressing hard on your chest to keep your blood pumping, (2) Electrical shocks to jump-start your heart, (3) Medicines in your veins.

   Ask your health care providers for more information as needed.

