

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these important facts:

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent (1) authorizes anything that is illegal, (2) acts contrary to your known desires, or (3) where your desires are not known, does anything that is clearly contrary to your best interests.

This power will exist for an indefinite period of time unless you limit its duration in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (1) authorize an autopsy, (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and (3) direct the disposition of your remains.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. Creation of Durable Power of Attorney for Health Care

By this document I intend to create a durable power of attorney by appointing the person designated below to make health care decisions for me, as allowed by the California Probate Code (sections 4600-4753). This power of attorney shall not be affected by my subsequent incapacity.

2. Designation of Health Care Agent

(Your agent must be an adult (at least 18 years of age). Insert the name, address, and telephone number of the person you wish to designate as your agent to make health care decisions for you. In most cases, none of the following may be designated as your agent: (1) your treating health care provider (for example, your doctor or your hospital) or an employee of your treating health care provider, (2) an operator or employee of a community care facility; or (3) an operator or employee of a residential care facility for the elderly. However, an employee of a treating health care provider, or community care facility or residential care facility for the elderly **may** be designated as your agent **if** such

person is your relative (by blood, marriage or adoption) **or if** such person is employed by the same treating health care provider, community care facility, or residential care facility for the elderly that employs you. For example, your agent may not be an employee of a hospital where you receive treatment unless the employee is related to you by blood, marriage or adoption, or unless you also work for the same hospital.)

I, (insert your name) _____, do hereby designate and appoint:

Name _____

Address _____

Telephone number (_____) _____ as my agent to make health care decisions for me as authorized in this document.

3. General Statement of Authority Granted

If I become incapable of giving informed consent with respect to health care decisions, I hereby grant to my agent full power and authority to make health care decisions for me, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, and to receive and to consent to the release of medical information, and, in the event of my death, to authorize an autopsy and arrange for the disposition of my remains, subject to the limitations and special provisions stated in Paragraph 6, below.

4. Contribution of Anatomical Gift

(You may choose to make a gift of all or part of your body to a hospital, physician, or medical school, for scientific, educational, therapeutic, or transplant purposes. California's Uniform Anatomical Gift Act allows such a gift. If you do not make such a gift, you may authorize your agent to do so, or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of all or a part of your body under the Uniform Anatomical Gift Act.)

If either statement below reflects your desires, sign the box next to the statement. You do not have to sign either statement.

If you do not sign either statement, your agent and your family will have the authority to make a gift of all or part of your body under the Uniform Anatomical Gift Act.

[_____] Pursuant to the Uniform Anatomical Gift Act, I hereby give, effective upon my death:

Any needed organ or parts; or

The parts or organs listed:

[_____] I do not want to make a gift under the Uniform Anatomical Gift Act, nor do I want my agent or family to do so.

5. Statement of Desires

(With respect to decisions to withhold or withdraw life-sustaining treatment, your agent must make decisions that are consistent with your known desires. You may, but are not required to, indicate your desires in the space below. If your desires are unknown, your agent has the duty to act in your best interests; and, under certain circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment,

services, and procedures. You may also include a statement of your desires concerning other matters relating to your health care. You may also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are types of treatments that you do not want to be used, you should state them in the space below.)

Statement of desires concerning life-prolonging care, treatment, services, and procedures:

6. Special Provisions and Limitations

(By law, your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. In every other respect, your agent may make health care decisions for you to the same extent that you could make them for yourself if you were capable of doing so. If there are any special restrictions you wish to place on your agent's authority, you should list them in the space below. If you do not list any limitations, your agent will have the broad powers to make health care decisions on your behalf, as set forth in Paragraph 3, above, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, the authority of my agent is subject to the following special provisions and limitations:

7. Designation of Alternate Agent

(You are not required to designate any alternate agents but you may do so. Each alternate agent must meet the requirements set forth in Paragraph 2, above. Any alternate agent you designate will be able to make the same health care decisions as the agent designated in Paragraph 2 above, in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in Paragraph 2 is your spouse, the law automatically revokes his or her designation as your agent if your marriage is dissolved.)

If the person designated as my agent in Paragraph 2 is unable or unwilling to make health care decisions for me or is disqualified by law from so doing, then I designate the following persons to serve as my agent in making health care decisions for me as authorized in this document. Such persons are to serve in the following order:

a. First Alternate Agent

Name _____

Address _____

Telephone number _____

b. Second Alternate Agent

Name _____

Address _____

Telephone number _____

8. Duration

I understand that this power of attorney will exist indefinitely, unless I establish a shorter time.

[Optional] I wish to have this power of attorney end on the following date: _____

9. Prior Designation Revoked

I revoke any prior Durable Power of Attorney for Health Care made by me.

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY

I sign my name to this Durable Power of Attorney for Health Care on [date] _____ at

[city] _____, [state] _____.

Signature _____

This Power of Attorney will not be valid for making health care decisions unless it is either

- 1) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature, or
- 2) acknowledged before a notary public in California.

Statement of Witnesses

(If you elect to use witnesses instead of having this document notarized, you should carefully read and follow this witnessing procedure, otherwise this document will not be valid.

You must use two qualified adult witnesses who personally know you. None of the following may be used as a witness: (1) a person you designate as your agent, (2) the principal's health care provider (for example, a doctor or a hospital), (3) an employee of the principal's health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility, (6) the operator of a residential care facility for the elderly, or (7) an employee of an operator of a residential care facility for the elderly. For example, your witness may not be a physician, a nurse, a hospital employee, a nursing home employee, or an operator of a board and care home. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

READ CAREFULLY BEFORE SIGNING. You may sign as a witness only if you personally know the principal or if the identity of the principal is proved to you by convincing evidence. To have convincing evidence of the identity of the principal, you must be presented with and reasonably rely on any one or more of the following:

1. An identification card or driver license issued by the California Department of Motor Vehicles that is current or has been issued within the previous five years.
2. A passport issued by the Department of State of the United States that is current or has been issued within the previous five years.
3. Any of the following documents if the document is current or has been issued within the previous five years and contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number.
 - a. A passport issued by a foreign government that has been stamped by the United States Immigration and Naturalization Service.
 - b. A driver license issued by a state other than California or by a Canadian or Mexican public agency authorized to issue driver licenses.
 - c. An identification card issued by a state other than California.
 - d. An identification card issued by any branch of the armed forces of the United States.
 - e. An inmate identification card issued by the state Department of Corrections, if the inmate is in custody.
4. If the principal is a patient in a skilled nursing facility, a witness who is a patient advocate or ombudsman may rely upon the representations of the administrator or staff of the skilled nursing facility, or of family members, as convincing evidence of the identity of the principal if the patient advocate or ombudsman believes that representations provide a reasonable basis for determining the identify of the principal.

5. Other kinds of proof of identity are not allowed.

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me to be the principal, or that the identity of the principal was proved to me by convincing evidence, that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact (agent) by this document, and that I am not the principal's health care provider, an employee of the principal'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.

Print Name _____

Signature _____

Residence Address _____

Date _____

Print Name _____

Signature _____

Residence Address _____

Date _____

**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 principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the principal's estate upon the principal's death under a will or codicil now existing or by operation of law.

Signature _____

Optional Second Signature _____

You may use this certificate of acknowledgment before a notary public instead of the statement of witnesses.

State of California

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SS.

County of _____

On [date]_____, before me, [name and title of officer]_____, personally appeared

[name(s) of signer(s)] _____

personally known to me **OR** proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal. (Civil Code section 1189)

[signature of notary]

Special Requirements

(Special additional requirements must be satisfied for this document to be valid if (1) you are a patient in a skilled nursing facility, or (2) you are a conservatee under the Lanterman-Petris-Short Act and you are appointing the conservator as your agent to make health care decisions for you. If you are not sure whether you are in a skilled nursing facility, which is a special type of nursing home, ask the facility staff.)

1. *If you are a patient in a skilled nursing facility (as defined in California Health and Safety Code section 1250(c)) the patient advocate or ombudsman must sign this document, either (1) as one of the two witnesses or (2), if this document is notarized, in addition to the notarization. The patient advocate or ombudsman must sign the witness statement and must also sign the following declaration.*

I declare under penalty of perjury under the laws of the State of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and am serving as a witness as required by subdivision (e) of Section 4701 of the Probate Code.

Print Name _____

Signature _____

Residence Address _____

Date _____

2. *If you are a conservatee under the Lanterman-Petris-Short Act (California Welfare and Institutions Code, Division 5) and you wish to designate your conservator as your agent to make health care decisions, you must be represented by legal counsel. Your lawyer must sign the following statement.*

I am a lawyer authorized to practice law in the state where this power of attorney was executed, and the principal was my client at the time this power of attorney was executed. I have advised my client concerning his or her rights in connection with this Durable Power of Attorney for Health Care and the applicable law and the consequences of signing or not signing this Durable Power of Attorney for Health Care, and my client, after being so advised, has executed this Durable Power of Attorney for Health Care.

Print Name _____

Signature _____

Residence Address _____

Date _____

COPIES: You should keep the executed original document and give a photocopy to your agent and to any alternate agents. You may also wish to give a copy to your doctor and to members of your family. The photocopies of this document that you give to your doctor and members of your family can be relied upon as though they were originals.