

CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE
(Appointing an Agent to Make Health Care Decisions)
California Probate Code Section 4701

My name is: _____

My address is: _____

In this document I appoint **an** agent. That agent will make health care decisions for me in the future, **if** and when I no longer have a **mental** capacity to **make my** own health care decisions. My agent must act consistently **with my desires** as stated in this document or otherwise made known.

Optional: I want my agent's authority to begin immediately, even though I currently have the mental capacity to **make my own** health care decisions. My decision to choose this option is proven by **my signature** here:

AGENT:

The following persons cannot be selected as your agent or alternate agent:

- Your primary physician.
- **An employee** of **the** health care institution or residential care facility where you **receive** care (unless you are related to that person).

Name: _____

Address: _____

Home phone: (_____) _____ Work phone: (_____) _____

1st ALTERNATE AGENT (If agent is unavailable or unwilling to serve.)

Name: _____

Address: _____

Home phone: (_____) _____ Work phone: (_____) _____

AGENT'S AUTHORITY

Except as limited by this document, my agent will have authority to **make** health care decisions for **me** to the **extent** that I now have authority to **make** my own health care **decisions**. This **authority includes**, but is not limited to, **the** authority 1) to accept or refuse treatment, **nutrition** and **hydration**, 2) to choose a particular physician or health care **facility**, and 3) to receive, or consent to **the** release of, **medical** information and records.

Also, except as limited **by** this document, this authority includes the authority to authorize an autopsy, donate **all** or **part** of **my body**, and/or determine the disposition of **my** remains. The agent's actions **must** be consistent with **my** will or trust, and with any funeral arrangements or other arrangements which I have made.

Autopsy _____

Donation of body/organs _____

Disposition of remains _____

HEALTH CARE INSTRUCTIONS (OPTIONAL)

I make the following instructions to my agent: (Attach additional pages **if** necessary.)

Permanent Unconsciousness (Optional; Select One or None)

If I am unconscious with no reasonable **expectation** of ever regaining consciousness (for **example**, in **an** irreversible coma), I **make** the following instruction to my agent, by **placing my signature** in front of my request:

_____ Authorize **all** treatments to prolong my life as long **as** possible.

_____ **Authorize the** treatment needed to provide me with food, water and pain control, **and to keep** me comfortable, hut otherwise do not authorize active treatment for my medical conditions.

_____ Authorize the **treatment needed** to provide **me** with **pain** control and to keep me **comfortable**, **but** do not authorize the provision of food or water through a tube or an intravenous line, and do not authorize active treatment for my medical conditions.

_____ The agent should use his or her discretion to authorize **and/or** refuse **treatment**.

Terminal Conditional (Optional; Select One or None)

If I am in a terminal condition, with death reasonably expected within six **months** or less, I **make** the following instruction to **my agent**, by **placing my signature** in front of my request:

_____ **Authorize** all treatments to prolong **my** life as long as possible.

_____ Authorize the treatment needed *to* provide me with food, water and pain control, and to keep me comfortable, **but** otherwise do not authorize active treatment for my medical conditions.

_____ Authorize the **treatment needed** to provide me with pain control and to **keep** me comfortable, **but do not** authorize the provision **of** food or water through a tube or an intravenous line, and do not authorize **active** treatment for **my** medical conditions.

_____ The agent, should **use** his or her discretion to authorize **and/or** refuse **treatment**.

REVOCAION OF PREVIOUS DOCUMENTS

I **revoke** any previously-executed Power of Attorney for Health Care, Individual Health Care Instruction, or Natural Death **Act Declaration**.

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.

SIGNATURE OF **PRINCIPAL (PERSON APPOINTING THE AGENT)**

Date: _____ Signature: _____

(If principal is not physically able to sign, he or she can **instruct another person** to sign the **principal's name**, **if signature** is done in the principal'' presence.)

WITNESSES

This document must either be notarized, **or** signed by two witnesses, If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a representative of California's Long-Term Care Ombudsman Program. If the two-witness method **is** chosen, **the** Ombudsman Program representative may serve **as** one of the **two** witnesses, or **may serve as** a third witness. If the notarization method is chosen, the Ombudsman Program representative serves **as** a separate **witness**,

Certain **individuals** cannot serve as witnesses. Those rules are set **forth** in the following witness **statements**.

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: _____
Name (printed) Signature

Date: _____ Address: _____

Second Witness: _____
Name (printed) Signature

Date: _____ Address: _____

ONE OF THE PRECEDING WITNESSES ALSO MUST 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 not existing or **by** operation of law.

Date: _____ Signature: _____

DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE

(Required if person appointing the agent currently resides in a nursing facility.)

I declare under penalty of **perjury** under the laws of California that I **am** an Ombudsman designated **by** the California Department of **Aging** and that I am serving as a witness **as** required by Section **4675** of **the** California Probate Code.

Date: _____ Signature: _____

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(Not required if two-witness method is followed)

State of California, County of _____

On this _____ day of _____, _____, **before** me, the undersigned, a Notary Public in and for said **State**, personally appeared _____, personally **known** to me or 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 it.

WITNESS my hand and official seal.

Signature _____