Durable Power of Attorney for Health Care of

_____

California Medical Association

(*see California Civil Code §§ 2410-2444*) (*see California Probate Code §§ 4600 - 4779*)

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a durable power of attorney for Health care. Before executing this document, you should know these important facts:

A. This document gives your "Agent," the person you designate as your attorney-in-fact the power to make health care decisions for you, subject to any limitations or statements of your desires that you include in this document. The power to make health care decisions for you may include 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. You may state in this document any types of treatment that you do not desire.

B. The agent(s) you designate in this document has a duty to act consistently with your desires as stated in this document or otherwise made known, or if your desires are unknown, to act in your best interests. 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.

C. Except as you otherwise specify in this document, the power of the agent(s) you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment necessary to, or which would, keep you alive.

D. 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 at the time, and health care necessary to keep you alive may not be stopped or withheld if you object.

E. You have the right to revoke the authority granted to the person designated in this document by notifying that agent of the revocation orally or in writing.

F. You have the right to revoke the authority granted to the agent(s) designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other health care provider orally or in writing.

G. The agent(s) designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

H. Unless you otherwise specify in this document, this document gives the agent(s) designated in this document to make health care decisions for you the power after you die to (a) authorize an autopsy, (b) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and (c) direct the disposition of your remains.

I. 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.

J. Do not use this form if you are a conservatee under the Lanterman-Petris-Short act and you want to appoint your conservator as your agent. You can do that only if you are represented by legal counsel who has executed a certificate of your attorney stating that you have been advised of your rights and the consequences of signing and not signing the power.

K. 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 Sections 2410 to 2444, inclusive, of the California Civil Code and Sections 4600 to 4805 of the California Probate Code. This power of attorney shall not be affected by my subsequent incapacity. I hereby revolve any prior durable power of attorney for health care. I am a California resident who is at least 18 years old, of sound mind, and acting of my own free will.

2. APPOINTMENT OF HEALTH CARE AGENT

A. I, _____, of _____, _____, born on _____, hereby designate and appoint _____, of _____, _____ as my agent (attorney-in-fact) to make health care decisions authorized in this document.

The following may **not** serve as your agent: **(1)** your treating health care provider; **(2)** an operator of a community care facility or residential care facility for the elderly; or **(3)** an employee of your treating health care provider, a community care facility, or a residential care facility for the elderly, unless that employee is related to you by blood, marriage or adoption. If you are a conservatee under the Lanterman-Petris-Short Act (the law governing involuntary commitment to a mental health facility) and you wish to appoint your conservator as your agent, you must consult a lawyer, who must sign and attach a special declaration for this document to be valid.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

A. If I become incapable of making or communicating informed health care decisions, I grant my agent full power and authority to make all health care decisions for me, to the same extent that I could make such decisions for myself, if I had the capacity to do so, subject to the limitations set forth in this document.

B. "Health care decisions" means grant, consent, refuse, refusal of consent, or withdrawal of consent on my behalf for any health care treatment, service, or procedure to affect my physical or medical information. This authority expressly includes the withholding or withdrawal of life-sustaining treatments.

C. I trust my agent, who knows and understands my desires, and in whose judgment I have absolute faith, to exercise that person's discretion, in a manner that would be satisfactory to me, if I had the capacity to give or refuse to give consent.

D. Before acting, my agent shall attempt to communicate with me regarding my desires unless such attempt would be futile. If I am unreachable by such communication, and my desires regarding a particular health care decision are unknown, my agent should make the health care decision guided by any references that I have previously expressed, by those, stated herein, and by information received from the attending physician(s) concerning my prognosis, all the

while having my best interests in mind.

E. If a"Treatment Preferences" or "Directive to Physician" under the California Health and Safety Codes is signed by me, whether it is signed before, in conjunction with, or after this Durable Power of Attorney for Health Care, it is my intention that the language in the California Health and Safety Codes should in no way limit the powers given to my agent in this document. If I have signed a Treatment Preference or Directive to Physician, it was with the hope that the cumulative effect of both documents would help implement my intentions.

4. STATEMENT OF DESIRES CONCERNING LIFE SUSTAINING TREATMENT AND SPECIAL PROVISIONS

A. Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires about the kinds of medical care you do or do not want, including your desires concerning life-sustaining treatment. If you do not want your agent to have the authority to make certain decisions you must either choose one of the statements below or write a statement to that effect in the space provided below; otherwise, your agent will have the broad powers to make health care decisions for you that are outlined in **Section 3 above**. In either case, it is important that you discuss your health care desires with the person you appoint as your agent.

You may choose between one of the three following statements, or write your own. You may also choose one of the three and still apply additional comments.	Initial the box(s) below that reflects your desire:
#1. I **DO NOT WANT** efforts made to prolong my life and I **DO NOT WANT** life-sustaining treatment to be provided or continued; **(1)** if I am in an irreversible coma or persistent vegetative state; or **(2)** if I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death; or **(3)** under any other circumstances where the burdens of treatment outweigh the expected benefits. I **WANT** palliative care - treatment for comfort; that is my agent is to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life sustaining treatment.	**If this statement reflects your desires; initial here:** _____
#2. I **WANT** efforts made to prolong my life and I **WANT** life-sustaining treatment to be provided **unless I am in a coma or persistent vegetative state** which my doctor reasonably believes to be irreversible. Once my doctor has concluded that I will remain unconscious for the rest of my life; I **DO NOT WANT** life-sustaining treatment to be provided or continued; however I **WANT** palliative care - treatment for comfort, even though I might be kept alive on machines for years in a hopeless condition.	**If this statement reflects your desires; initial here:** _____
#3. I **WANT** efforts made to prolong my life and I **WANT** life-sustaining treatment to be provided **even if** I am in an irreversible coma or persistent vegetative state. I realize that this means that I might be kept alive on machines for years in a hopeless condition. Additionally, I **WANT** palliative care - treatment for comfort.	**If this statement reflects your desires; initial here:** _____
Other or additional statements of medical treatment desires and limitations: _____ _____ _____ _____	You may attach additional pages. Each additional page must be dated and signed at the same time you date and sign this document.

B. Below are listed some situations I may encounter. I recognize these cannot exactly predict what might happen but I instruct my agent to use this information to the best of his/her ability in making treatment decisions for me and on my behalf.

1. TERMINAL ILLNESS WITHOUT EXPECTATION OF RECOVERY AND PERMANENTLY LACKING DECISION MAKING CAPABILITY.

If the situation should arise in which I am in a terminal condition, am permanently lacking of decision making capability, and there is no reasonable expectation of my recovery, I direct that I be allowed to die a natural death and that my life not be prolonged by extraordinary measures. I do, however, ask that medication be given to me as necessary, to relieve pain and suffering even though this may shorten my remaining life.

YES_____ NO____.

2. PERMANENT UNCONSCIOUSNESS.

Whether or not I am terminally ill, if I become permanently unconscious, I direct that life support be discontinued. **YES_____ NO____.**

3. BRAIN DAMAGE--UNABLE TO COMMUNICATE.

Whether I am terminally ill or not, if I become unconscious and have very little chance of ever recovering consciousness, and would almost certainly be very brain-damaged if I did recover consciousness, I direct that life support be discontinued. **YES_____ NO____.**

4. DOES LIFE SUPPORT INCLUDE FOOD AND FLUIDS?

The above situations (1, 2, or 3) may occur such that life can be prolonged when food and fluids are provided by tubes or other invasive measures. These include TUBES IN THE NOSE OR STOMACH, and INTRAVENOUS FEEDINGS. If one of these situations develops, I direct that tubes or other invasive measures for providing food and fluids **not be** started. If they are started, they are to be discontinued in the following situations (see above descriptions):

a. Terminal illness **YES_____ NO____.**

b. Permanent unconsciousness **YES_____ NO____.**

c. Brain damage **YES_____ NO____.**

I direct that although other forms of life-sustaining therapies may be withheld or withdrawn as directed by my agent, food and fluids **are** to be given or maintained. **INITIALS____.**

5. TRIAL OF THERAPY.

If I am not terminally ill but recovery is very unlikely (5% or less chance of getting better), I request that a trial of therapy be given as determined by my agent and my physician(s). This therapy may include (but is not limited to) mechanical ventilation, antibiotics, and artificially provided feedings.

YES_____ NO____.

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

A. My agent shall request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

B. My agent shall execute, on my behalf, any release or other documents that may be required in order to obtain this information.

C. I consent to disclosure of this information. My agent has the power and authority to execute any and all documents that relate to my health care decisions, including, but not limited to the following: Documents titled or purported to be a "Refusal to Permit Treatment" or "Leaving Hospital Against Medical Advice," and any necessary waiver or release from liability.

6. AUTOPSY, ANATOMICAL GIFTS, DISPOSITION OF REMAINS

A. My agent **[IS] [IS NOT]** hereby directed to authorize an autopsy (under applicable state laws).

B. My agent is hereby directed that I **[DO] [DO NOT]** desire to donate my body or any of its organs as anatomical gifts for transplant and research.

C. I direct that my funeral shall be conducted at _____ and that my remains be buried at _____. My Executor shall pay all expenses related not otherwise prepaid prior to any distributions of my estate.

7. DESIGNATION OF ALTERNATE AGENT(S)

If the person I designated as my agent in paragraph 2 is unable or unwilling to act as my agent, or if I revoke that person's appointment as my agent, then I designate the following person(s) to serve as my agent, to serve in the order listed below, to make health care decisions for me, as authorized in this document:

First Alternate Agent: _____
Street Address: _____
City, State & Zip Code: _____
Telephone Number: ( )_____

Second Alternate Agent: _____
Street Address: _____
City, State & Zip Code: _____
Telephone Number: ( )_____

8. REVOCATION

I revoke any prior durable power of attorney for health care.

9. USE OF COPIES

I hereby authorize that photocopies of this document can be relied upon by my agent and others as though they were originals.

10. TERMINATION OF THIS DOCUMENT

This Durable Power of Attorney for Health Care Decision will terminate on _____.

11. PATIENT IN A NURSING FACILITY

If you are a patient in a skilled nursing facility, you must use witnesses rather than a notary public, and at least one of the witnesses must be a patient advocate or ombudsman.

STATEMENT OF WITNESSES

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[1], that the principal signed or acknowledged this durable power of attorney 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 by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility or a residential care facility for the elderly, nor an employee of an operator of a community care facility or residential care facility for the elderly.

Signature: _____

Print name: _____

Residence Address:_____

_____ Date: _____

Signature: _____

Print Name: _____

Residence Address: _____

_____ Date: _____

[1] The law allows one or more of the following forms of identification as convincing evidence of identity: a California driver's license or identification card or U.S. passport that is current or has been issued within five years, or any of the following if the document is current or has been issued within five years, 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 foreign passport that has been stamped by the U.S. Immigration and Naturalization Service: a driver's license issued by another state or by an authorized Canadian or Mexican agency: or an identification card issued by another state or by any branch of the U.S. armed forces. If the principal is a patient in a skilled nursing facility, a patient advocate or ombudsman may rely on the representations of family members or the administrator or staff of the facility as convincing evidence of identity if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.

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 estate of the principal upon the death of the principal under a will now existing or by operation of law."

Witness Signature:_____

SPECIAL REQUIREMENT: STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

(If you are a patient in a skilled nursing facility, one of your witnesses must be a patient advocate or ombudsman, who must sign the statement of witness above *and* must also sign the following declaration.)

I further 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 am serving as a witness as required by subdivision (f) of Civil Code Section 2432; subdivision (e) of Probate Code Section 4701; and subdivision (a) of Probate Code Section 4675 after June 30, 2000.

Signature: _____

Address: _____

Print Name: _____ Date: _____

DATE AND SIGNATURE OF PRINCIPAL

Executed on _____, 20_____ at _____, California.

_____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of California)
County of _____)

On_____, 20___, before me, _____, 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 she executed the same in her authorized capacity, and that by her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

Witness my hand and official seal:

Signature _____
My Commission Expires _____