University of California
San Francisco

UCSF Medical Center

ADVANCE HEALTH CARE DIRECTIVE

FOR

NAME: ______________________________

DOB: ______________________________

MR#: ______________________________

876-053 (02/01, 02/01)

ADVANCE HEALTH CARE DIRECTIVE

WARNING TO PERSON EXECUTING THIS DOCUMENT

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

You have the right to give instructions about your own health care. You also have the right to name someone else (your agent) to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your specific wishes, if any, regarding life-support treatments and organ donation. If you use this form, you may complete or modify all or any part of it. If there is anything on this form you do not understand, you should contact your primary care physician or an attorney.

Instructions

PART I - DESIGNATION OF AGENT

Part I allows you to name another individual as your agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known by you.

Your agent may not be any of the following: (a) your primary treating health care provider; (b) an operator of a community care or residential care facility where you receive care; or (c) an employee of the health care institution or community or residential care facility where you receive care. These prohibitions shall not apply if your agent is an employee who is related to you by blood, marriage or adoption.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. Should you become incapacitated, your agent will also have the authority to make decisions relating to your personal care, including but not limited to, determining where you will live, providing meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment. This form has a place for you to limit the authority of your agent if you wish. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made.

If you choose not to limit the authority of your agent, your agent will have the right to:

1. **Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.**
2. **Select or discharge health care providers and institutions.**
3. **Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.**

4. **Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation (CPR.)**
5. **Authorize an autopsy, donate your body or parts thereof for transplant, therapeutic, educational or scientific purposes and direct the disposition of your remains.**
6. **Examine your medical records and consent to their disclosure.**

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.

By operation of law, your agent may not consent to committing or placing you in a mental health treatment facility, or to convulsive treatment, psychosurgery, sterilization or abortion.

You may state in this document any types of treatment that you do not desire. 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.

Your agent's authority becomes effective when your primary physician determines that you are unable to make your own health care decisions unless you indicate otherwise. You may choose to have your agent's authority become effective immediately.

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 at any time by notifying your agent, treating physician, hospital or other health care provider orally or in writing of the revocation. Completing a new Advance Health Care Directive will revoke all previous directives. If you revoke a prior directive, notify every person and hospital, clinic or care facility that has a copy of your prior directive and give them a copy of your new directive.

Photocopies of this document can be relied upon by the appointed health care agent and others as though they were the original. Place the original in an accessible, safe place so that it can be located if needed. Tell your agent and a family member where you keep the original. Give photocopies of the original to (1) your agent and any alternative agents, (2) your primary care physician or other health care providers and (3) members of your family and/or any other person who might be called in the event of a medical emergency.

PART II - INSTRUCTIONS FOR HEALTH CARE

You may, but are not required to, state your desires about the goals and types of medical care you do or do not want, including your desires concerning life support if you become seriously ill. If your wishes are not known, your agent must make health care decisions for you that your agent believes to be in your best interest, considering your personal values. **If you do not wish to provide specific, written health care instructions, draw a line through Section II.**

PART III - DONATION/DISPOSITION OF ORGANS

You may express an intention to donate some or all of your bodily organs and tissues following your death and identify the purpose of the donation.

PART IV - SIGNATURE

After completing this form, provide your signature and the date of execution where indicated.

PART V - WITNESS REQUIREMENTS

This Advance Health Care Directive will not be valid unless it is either signed by two qualified witnesses or acknowledged before a notary public in California. If you use witnesses rather than a notary public, **the law prohibits using the following as witnesses:** (1) the persons you have appointed as your alternative agent(s); (2) your health care provider or an employee of your health care provider; or (3) an operator or employee of an operator of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses **cannot** be related to you by blood, marriage, adoption, be named in your will, or by operation of law be entitled to any portion of your estate upon your death.

Special Rules for Skilled Nursing Facility Residents - If you are a patient in a skilled nursing facility, you must have a patient advocate or Ombudsman sign as a witness and sign the Statement of Patient Advocate or Ombudsman. You must also have a second qualified witness execute this form or have this document acknowledged before a notary public.

PART I - DESIGNATION OF AGENT

I ________________________________, designate the following individual as my
(Print Name)

agent to make health care decisions for me:

Name: ____

Address: ____
(Street Address, City, State, Zip Code)

Telephone: ____
(Home Phone) (Work Phone)

OPTIONAL- FIRST ALTERNATE AGENT: 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: ____

Address: ____
(Street Address, City, State, Zip Code)

Telephone: ____
(Home Phone) (Work Phone)

OPTIONAL- SECOND ALTERNATE AGENT: 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: ____

Address: ____
(Street Address, City, State, Zip Code)

Telephone: ____
(Home Phone) (Work Phone)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE (choose one):

☐ My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

☐ My agent's authority becomes effective immediately.

DURATION OF AGENT'S AUTHORITY

I understand that this Advance Health Care Directive will be effective from the date I execute this document and will exist indefinitely, unless I specify a shorter time. I can revoke this document at any time by telling my health care provider and my designated agent that I no longer want it to be effective.

OPTIONAL: This Advance Health Care Directive will only be effective until the following date:

________/________/________
(Month) (Day) (Year)

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 II 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 by 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 III of this form:

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PART II - INSTRUCTIONS FOR HEALTH CARE

If you do not wish to provide specific, written health care instructions, you may draw a line through this Section.

The following are statements about the use of life-support treatments. Life-support or life-sustaining treatments are any medical procedures, devices or medications used to keep you alive. Life-support treatments may include the following: medical devices put in you to help you breathe; food and fluid supplied artificially by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusion; kidney dialysis; and antibiotics.

Sign either of the following general statements about life-support treatment if one accurately reflects your desires. If you wish to modify or add to either statement or to write your own statement instead, you may do so in the space provided or on a separate sheet(s) of paper which you must date and sign and attach to this form.

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 to not prolong life**

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) 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 stated in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

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OPTIONAL: My agent is authorized to make all health care decisions for me except as I state here (use more sheets if necessary):

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PART III - DONATION/DISPOSITION OF ORGANS (choose one):

☐ I wish to donate ANY needed organs, tissues, or parts.

☐ I wish to donate ONLY the following organs, tissues, or parts:

____

☐ I do NOT wish to donate any organs, tissues, or parts.

OPTIONAL: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as stated here (use more sheets if necessary):

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PART IV - SIGNATURE

I hereby sign my name to and acknowledge this Advance Health Care Directive. By my signature, I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration. I understand that a copy of this form has the same effect as the original:

____________________ at ____________________, ____________________

(Date) (City) (State)

____

Signature

PART V - STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of the state 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[1] (2) that the individual signed or acknowledged this Advance Health Care 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 Health Care Directive, and (5) that I am not the individual's health care provider nor an employee of that health care provider, nor an operator or employee of an operator of a community care facility or a residential care facility for the elderly.

Witness #1:____**Date:** ________________
(Signature)

Print Name:____

Address: ____

Witness #2:____**Date:** _______________
(Signature)

Print Name:____

Address: ____

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION:

I further declare under penalty of perjury under the laws of the state 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: __________________________________ Date: ______________________

FOR SKILLED NURSING FACILITIES: STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I further 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 Probate Code Section 4675.

Name/Title Printed:__________________________ Date: _______________________

Signature:____

Address: ____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

Acknowledgment before a notary public is not required if two qualified witnesses have signed above. If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign the Statement of Witnesses and the Statement of Patient Advocate or Ombudsman above, even if you also have this form notarized.

State of California)

) SS.

)

County of ________________)

On this ____________________, before me, ______________________________
(Date) (Name and Title of Officer)

personally appeared ____
(Name of Signer)

personally known to me (or proved 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.

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(Signature of Notary Public) **Notary Seal**

[1] **EVIDENCE OF IDENTITY:** The following forms of identification are satisfactory 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; an identification card issued by another state or by any branch of the U.S. armed forces, or for an inmate in custody, an inmate identification card issued by the Department of Corrections. 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.