Part 3: Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death. included in the form) or acknowledged before a notary public. A notary is not required if the form is signed by two witnesses.

Part 4: Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Part 5: Signature and Witnesses

After completing the form, sign and date it in the section provided.

The form must be signed by two qualified witnesses (see the statements of the witnesses

Part 6: Special Witness Requirement

A Patient Advocate or Ombudsman must witness the form if you are a patient in a skilled nursing facility (a health care facility that provides skilled nursing care and supportive care to patients). See Part 6 of the form.

You have the right to change or revoke your Advance Health Care Directive at any time

If you have questions about completing the Advance Directive in the hospital, please ask to speak to a Chaplain or Social Worker.

We ask that you complete this form in English so your caregivers can understand your directions.
Advance Health Care Directive

Name__________________________________________

Date__________________________________________

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

Part 1 — Power of Attorney for Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent:__________________________________________

Relationship______________________________________________________________

Address: '______________________________________________________________
_____________________________________________________________________

Telephone numbers: (Indicate home, work, cell) __________________________________

ALTERNATE AGENT (Optional): 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 of individual you choose as alternate agent:____________________________________

Relationship______________________________________________________________

Address: _______________________________________________________________
_____________________________________________________________________

Telephone numbers: (Indicate home, work, cell) __________________________________

SECOND ALTERNATE AGENT (optional): 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 of individual you choose as second alternate agent: __________________________

Address: _______________________________________________________________
_____________________________________________________________________

Telephone numbers: (Indicate home, work, cell) __________________________________

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(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including
decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health
care to keep me alive, 2) choose a particular physician or health care facility, and 3) receive or consent to
the release of medical information and records, except as I state here:

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective
when my primary physician determines that I am unable to make my own health care decisions unless I
initial the following line.

If I initial this line, I want my agent to make health care decisions for me immediately even though I am still
able to make them for myself. ___

(1.4) 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 2 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 my best interest. In determining my
best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST DEATH 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 3 of this form:

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by
a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably avail-
able to act as conservator, I nominate the alternate agents whom I have named. _____ (initial here)

Part 2 — Instructions for Health Care

If you fill out this part of the form, you may strike out any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct my health care providers and others involved in my care to
provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ a) Choice Not To Prolong
   I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the
   expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not
   regain consciousness, or if I have an incurable and irreversible condition that will result in my death in
   a relatively short time.
   Or

☐ b) Choice To Prolong
   I want my life to be prolonged as long as possible within the limits of generally accepted medical
treatment standards.

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OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

(Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

☐ I give any needed organs, tissues, or parts

☐ I give the following organs, tissues or parts only: ________________________________

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

My gift is for the following purposes (strike out any of the following you do not want):

Transplant    Therapy    Research    Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of Physician: ____________________________________________

Address: ______________________________________________________

Telephone: ____________________________________________________

Part 5 — Signature

(5.1) EFFECT OF A COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign name: ________________________________ Date: __________

(5.3) STATEMENT OF WITNESSES: 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
Print Name: ____________________________
Address: ______________________________
Signature of Witness: __________________ Date: __________

SECOND WITNESS
Print Name: ____________________________
Address: ______________________________
Signature of Witness: __________________ Date: __________

5.4 ADDITIONAL STATEMENT OF WITNESSES: 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 individual executing this advance 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 on his or her death under a will now existing or by operation of law.
Signature of Witness: __________________
Signature of Witness: __________________

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility
6.1) The patient advocate or ombudsman must sign the following statement:
STATEMENT OF 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:
Print Name: ____________________________ Signature: __________________
Address: ______________________________ Date: __________

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses)
State of California, County of ____________________________
On this ____________________________ (date) before me _______________________,
Notary Public, personally appeared _________________________(name(s) of signer(s)),
who 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.
I certify under PENALTY OF PERJURY under the laws of the state of California that the foregoing paragraph is true and correct.
WITNESS my hand and official seal. Seal
Signature of Notary ________________________