

My Health Care Wishes

The
California
Medical
Association's

Advance Health Care Directive Kit

For more information on Advance Health
Care Directives, see www.cmanet.org



LIST OF PEOPLE AND PLACES THAT HAVE A COPY OF MY ADVANCE DIRECTIVE

After you have completed your Advance Health Care Directive form (included in this kit), you should give copies of the form to the people you have appointed as your agent and alternate agents, to your doctor(s), and to family members or anyone else who is likely to be called if there is a medical emergency. You should also take a copy with you if you are going to be admitted to a hospital, nursing home or other health facility.

Use the space below to keep a list of the people and institutions who have copies of your Advanced Directive so that you can contact them if you decide to revoke, update, or revise it. Be sure to advise everyone on the list of any changes, revocation or revision of a prior Advance Directive and send any new or updated Advance Directive to those you deem appropriate at that time.

My Full Name: _____

My Phone: (_____) _____ Date of my Advance Directive: _____

People and Institutions Who Have a Copy of My Advance Directive:

Name: _____ Name: _____

Address: _____ Address: _____

Phone: (_____) _____ Phone: (_____) _____

Fax: (_____) _____ Fax: (_____) _____

Name: _____ Name: _____

Address: _____ Address: _____

Phone: (_____) _____ Phone: (_____) _____

Fax: (_____) _____ Fax: (_____) _____

Name: _____ Name: _____

Address: _____ Address: _____

Phone: (_____) _____ Phone: (_____) _____

Fax: (_____) _____ Fax: (_____) _____

Name: _____ Name: _____

Address: _____ Address: _____

Phone: (_____) _____ Phone: (_____) _____

Fax: (_____) _____ Fax: (_____) _____

TO ORDER MORE COPIES OF THE ADVANCE HEALTH CARE DIRECTIVE KIT, OR OTHER CMA PUBLICATIONS:

4 WAYS TO ORDER CMA PUBLICATIONS



PHONE in your Visa or MasterCard orders to **800/882-1262**, Monday to Friday 9-5PM.



FAX to **916/551-2035**. Please include your Visa or MasterCard account number, name and signature.



WEB—Order online at CMA's Bookstore at **www.cmanet.org**. It's fast and easy.



MAIL your payment and request to:
CMA Publications
1201 J Street, Suite 375
Sacramento, CA 95814-2906

Introduction to Advance Health Care Directives

California law gives you the ability to ensure that your health care wishes are known and considered if you become unable to make these decisions yourself.

The following are answers to commonly asked questions about Advance Health Care Directives. For more information, see www.cmanet.org.

What is an Advance Health Care Directive?

An Advance Health Care Directive is the best way to make sure that your health care wishes are known and considered if for any reason you are unable to speak for yourself. Completing a form called an “Advance Health Care Directive” allows you, under California law, to do a number of things:

First, you may appoint another person to be your health care “agent.” This person (who may also be known as your “attorney-in-fact”) will have legal authority to make decisions about your medical care if you become unable to make these decisions for yourself. Although you are not required to appoint a health care agent, the California Medical Association (CMA) recommends that you do so. Appointing a particular person as your health care agent ensures there will be someone you trust to actively participate in the decisions surrounding your health care.

Second, you may write down your health care wishes in the Advance Health Care Directive form, for example, a desire not to receive treatment that only prolongs the dying process if you are seriously ill. Your doctor and your agent must follow your lawful instructions within the limits of generally accepted health care standards.

Third, an Advance Health Care Directive allows you to express your wishes about organ and tissue donation.

Is an Advance Health Care Directive different from a “living will”?

The Advance Health Care Directive is now the legally recognized format for a living will in California. It replaces the Natural Death Act Declaration. The Advance Health Care Directive allows you to do more than the traditional living will, which only states your desire not to receive life-sustaining treatment if you are terminally ill or permanently unconscious. An Advance Health Care Directive allows you to state your wishes about refusing or accepting life-sustaining treatment in any situation.

Unlike a living will, an Advance Health Care Directive also can be used to state your desires about your health care in any situation in which you are unable to make your own decisions, not just when you are in a coma or are terminally ill. In addition, an Advance Health Care Directive allows you to appoint someone you trust to speak for you when you are incapacitated.

You do not need a separate living will if you have already stated your wishes about life-sustaining treatment in an Advance Health Care Directive. The Advance Health Care Directive form in this kit includes an optional living will statement that you can select if it reflects your desires.

Is an Advance Health Care Directive different from a “Durable Power of Attorney for Health Care”?

The Advance Health Care Directive has replaced the Durable Power of Attorney for Health Care (or “DPAHC”) as the legally recognized document for appointing a health care agent in California. The Advance Health Care Directive allows you to do more than a DPAHC. An Advance Health Care Directive permits you not only to appoint an agent, but to give instructions about your own health care. You can now do either or both of these things in the same document.

What if I have already executed a Durable Power of Attorney for Health Care or a Natural Death Act Declaration. Is it still valid? Do I have to complete an Advance Health Care Directive?

All valid Durable Powers of Attorney for Health Care (DPAHC) and Natural Death Act Declarations remain valid. Thus, unless your existing DPAHC has expired, you do not have to complete an Advance Health Care Directive. A DPAHC executed before 1992 has expired and should be replaced.

Because the Advance Health Care Directive gives you more flexibility to state your health care desires, you may wish to complete the new form even if you previously completed a DPAHC or Natural Death Act Declaration. At a minimum, you should review your existing DPAHC or Natural Death Act Declaration to make sure it has not expired and that it still accurately reflects your wishes.

Is an Advance Health Care Directive different from “POLST”?

Yes. An Advance Health Care Directive allows you to make your health care wishes known in the event you are unable to speak for yourself or prefer someone else to speak for you, and allows you to legally appoint that person as your agent for health care decisions. By way of your Advance Health Care Directive, you can identify your primary physician as well as specify your preferences about accepting or refusing life-sustaining treatment such as CPR, feeding tubes or breathing machines, about receiving or declining pain medications, making organ donations, and otherwise formally express your health care wishes, values and beliefs.

“POLST,” or Physician Orders for Life-Sustaining Treatment, became a legally recognized option in California in 2009. POLST is intended to complement an Advance Health Care Directive, particularly for those who are seriously ill or have been diagnosed with a terminal illness. Having a completed and fully executed POLST form means that your end-of-life health care wishes

have been translated into actionable physician orders. Thus, POLST can help ensure that your health care wishes are implemented and followed without delay.

You may order a POLST kit, which includes the POLST form and answers to frequently asked questions, from CMA publications. Please see the inside front cover of this kit for ordering information.

Who can complete an Advance Health Care Directive?

Any California resident who is at least eighteen (18) years old (or is an emancipated minor), of sound mind, and acting of his or her own free will can complete a valid Advance Health Care Directive.

Do I need a lawyer to complete an Advance Health Care Directive?

No. You do not need a lawyer to assist you in completing an Advance Health Care Directive form (such as the form supplied in the this kit). The only exception applies to individuals who have been involuntarily committed to a mental health facility who wish to appoint their conservator as their agent.

Who may I appoint as my health care agent?

You can appoint almost any adult to be your agent. You can choose a member of your family such as your spouse or an adult child, a friend, or someone else you trust. You can also appoint one or more “alternate agents” in case the person you select as your health care agent is unavailable or unwilling to make a decision. (If you appoint your spouse and later get divorced, the Advance Health Care Directive remains valid, but your first alternate agent will become your agent).

It is important that you talk to the people you plan to appoint to make sure they understand your wishes and agree to accept this responsibility. Your health care agent will be immune from liability so long as he or she acts in good faith.

The law prohibits you from choosing certain people to act as your agent(s). You may not choose your doctor, or a person who operates a community care facility (sometimes called a “board and care home”) or a residential care facility in which you receive care. The law also prohibits you from appointing a person who works for the health facility in which you are being treated, or the community care or residential care facility in which you receive care, unless that person is related to you by blood, marriage, or adoption, or is a co-worker.

Can I appoint more than one person to share the responsibility of being my health care agent?

The California Medical Association (CMA) recommends that you name only one person as your health care agent. If two or more people are given equal authority and they disagree about a health care decision, one of the important purposes of the Advance Health Care Directive to identify clearly who has authority to speak for you will be defeated. If you are afraid of offending people close to you by choosing one over another to be your agent, ask them to decide among themselves who will be the agent, and list the others as alternate agents.

I want to provide more specific health care instructions than those included on this form. How do I do that?

You may write detailed instructions for your health care agent and physician(s). To do so, simply attach one or more sheets of paper to the form, write your instructions, write the number of pages you are attaching in the space provided at the end of Section 5, and sign and date the attachments at the same time you have the form witnessed or notarized. For examples of more specific instructions, go to the California Medical Association’s website at www.cmanet.org.

How much authority will my health care agent have?

If you become unable to make your own health care decisions, your agent will have legal authority to speak for you in health care matters. Physicians and other health care professionals will look to your agent for decisions rather than your next of kin or any other person. Your agent will be able to accept or refuse medical treatment, have access to your medical records, and make decisions about donating your organs, authorizing an autopsy, and disposing of your body should you die.

If you do not want your agent to have certain powers or to make certain decisions, you can write a statement in the Advance Health Care Directive form limiting your agent’s authority. In addition, the law says that your agent cannot authorize convulsive treatment (i.e., electroconvulsive therapy or ECT), psychosurgery, sterilization, abortion, or placement in a mental health treatment facility.

The person you appoint as your agent has no authority to make decisions for you until you are unable to make those decisions yourself, unless you choose to allow your agent to make those decisions for you immediately.

When you become incapacitated, your agent must make decisions that are consistent with any instructions you have written in the Advance Health Care Directive form or made known in other ways, such as by telling family members, friends or your doctor. If you have not made your wishes known, your agent must decide what is in your best interests, considering your personal values to the extent they are known.

What should I tell my family, my health care agent, and my doctors?

One of the most important parts of completing an Advance Health Care Directive is the conversations you have about it with your loved ones and your

physician(s). You should talk about your personal values and what makes living meaningful for you; your current medical condition and decisions you may foresee in the future; specific concerns or wishes you may have regarding life support or aggressive interventions, hospice or long-term care; what concerns you most about death or dying; and how you would want to spend the last month of your life. It is recommended, although not always possible, that such a discussion include your physician(s) as well as your health care agent (and alternate agent(s)).

Tell your loved ones that you have completed an Advance Health Care Directive and what you have said in it, especially if you have selected a health care agent. Your Advance Health Care Directive will likely go into effect during a period of crisis for them. It can help ease their burden to know that you have made some of these decisions in advance. In addition, they should know in advance who is to speak for you in making medical decisions and where copies of your Advance Health Care Directive can be found. Remind them that their role is to make sure that your wishes are communicated and that those wishes guide their decision making.

Will my health care agent be responsible for my medical bills?

No, not unless that person would otherwise be responsible for your debts. The Advance Health Care Directive deals only with medical decision making and has no effect on financial responsibility for your health care. Please note, however, that unless you have made other arrangements, your agent may be responsible for costs related to the disposition of your body after you die. Consult an attorney regarding how your financial affairs should best be handled.

How long is an Advance Health Care Directive valid?

An Advance Health Care Directive is valid forever, unless you revoke it or state in the form a specific date on which you want it to expire.

What should I do with the Advance Health Care Directive form after I fill it out?

Make sure that the form has been properly signed, dated, and either notarized or witnessed by two qualified individuals (the form includes instructions about who can and cannot be a witness). Keep the original in a safe place where your loved ones can find it quickly. Give copies of the completed form to the people you have appointed as your agent and alternate agent(s), to your doctor(s), and to family members or anyone else who is likely to be called if there is a medical emergency. You should tell these people to present a copy of the form at the request of your health care providers or emergency medical personnel.

Take a copy of the form with you if you are going to be admitted to a hospital, nursing home or other health care facility. Copies of the completed form can be relied upon by your agent and doctor(s) as though they were the original.

You should also fill out the contact list provided on the inside front cover of this kit. This will facilitate communication of any changes you make to your Advance Directive later. Make sure you include the name, address, and telephone and fax numbers for each person or facility to whom you have given a copy of your Advance Health Care Directive.

You may also wish to register your Advance Directive with the State of California voluntary Advance Health Care Directive Registry. The registration form and more information about the registry is available on the Secretary of State's website at www.sos.ca.gov/ahcdr.

What if I change my mind after completing an Advance Health Care Directive?

You can revoke or change an Advance Health Care Directive at any time. To revoke the entire form, including the appointment of your agent, you must inform your treating health care provider personally or in writing. Completing a new CMA Advance Health Care Directive will revoke all previous directives. In addition, if you revoke or change your Advance Directive, you should notify every person or facility that has a copy of your prior directive and provide a copy of your new directive to those you then deem appropriate.

If you revoke your Advance Health Care Directive or change the treatment preferences identified therein and you also have Physician Orders for Life-Sustaining Treatment, "POLST," in place, be certain to also revoke or change your POLST and all copies thereof. You should handle revocation or changing of your POLST, and distribution of any new POLST, in the same manner as suggested for your Advance Health Care Directive. Remember that in the event you are unable to speak for yourself, or in a situation in which you choose to have someone else speak for you, you want your most recent wishes and intentions to be known and not to be confused with prior preferences or decisions that may have been made under different circumstances.

You should complete a new Advance Health Care Directive if you want to name a different person as your agent or make other changes. However, if you need only to update the address or telephone numbers of your agent or alternate agent(s), you may write in the new information, and initial and date the change. Of course, you should make and distribute copies or otherwise ensure that those who need this new contact information will have it.

You should make a list of the people and institutions to whom you give a copy of the form so you will know whom to contact if you revoke the Advance Health Care Directive, update contact information, or make a new

one. The inside front cover of this CMA kit provides a place for this list.

How will emergency personnel (such as paramedics) find my Advance Health Care Directive form in the event of an emergency?

On the back cover of the CMA kit you will find two Advance Health Care Directive Wallet Identification cards. You should complete both cards. Keep one for yourself and give one to your spouse or someone who is likely to be contacted should you be in an emergency situation. The cards should be kept where emergency health care personnel will find them, such as in a wallet.

I have reached a point in my life that I don't want the paramedics to give me CPR. Will this Advance Health Care Directive keep this from happening?

If the paramedics see your Advance Health Care Directive before they start resuscitative efforts, and the Advance Health Care Directive clearly instructs them not to start these efforts, they probably will not start resuscitation.

Another approach is to complete the "Prehospital Do Not Resuscitate (DNR)" form and obtain a "Do Not Resuscitate – EMS" medallion approved by California's Emergency Medical Services Authority. The medallion, worn as a bracelet or necklace, is most readily observable and identifiable in an emergency situation. You may order copies of the DNR form (which includes instructions on ordering the medallion) from CMA publications. Please see the inside front cover for ordering information.

Your wishes regarding resuscitation can also be included in your Physician Orders for Life-Sustaining Treatment, or "POLST," which may be appropriate for patients with a serious medical condition or who have been diagnosed with a terminal illness. For more information, review the POLST kit, available from CMA Publications. Please see the inside front cover of this kit for ordering information.

Is my Advance Health Care Directive valid in other states?

An Advance Health Care Directive that meets the requirements of California law may or may not be honored in other states, but most states will recognize an Advance Health Care Directive that is executed legally in another state. If you spend a lot of time in another state, you may want to consult a doctor, lawyer, or the medical society in that state to find out about the laws there.

Can anyone force me to sign an Advance Health Care Directive?

No. The law specifically says that no one can require you to complete an Advance Health Care Directive before admitting you to a hospital or other health care facility, and no one can deny you health insurance because you choose not to complete an Advance Health Care Directive.

Can I get more information about the Advance Health Care Directive?

Yes. Your doctor probably can provide you with more information. However, you should talk to a lawyer if you want legal advice.

Can I get more information about Physician Orders for Life-Sustaining Treatment (“POLST”)?

Yes. If you have a serious medical condition or have been diagnosed with a terminal illness, CMA encourages you to talk to your doctor about POLST. Before initiating that conversation with your doctor, you may wish to visit www.CAPOLST.org for more information and order the POLST Kit from CMA Publications. The Kit includes the POLST form on the recommended Pulsar Pink cardstock paper and provides answers to frequently asked questions. Reviewing those materials will help you understand the purpose and use of POLST and, as a result, should

facilitate an informed discussion with your doctor about POLST and the decisions that can be reflected in a POLST form.

For more information about end-of-life medical decisions, go to www.finalchoices.org, the website for the California Coalition for Compassionate Care.

The booklet “Finding Your Way” is a useful guide to thinking about and discussing these issues. To order a copy, send \$1.50 check (payable to “CHCD”) to Center for Healthcare Decisions, 3400 Data Drive, Rancho Cordova, CA 95670 or order it through their website, www.chcd.org.

MY HEALTH CARE WISHES

This form lets you give instructions about your future health care. It also lets you name someone to make decisions for you if you can't make your own decisions. It's best if you fill out the whole form, but, as long as it is signed, dated and witnessed or notarized properly, you may choose only to appoint an agent (section 1) or provide health care instructions (section 5). If there is anything in this form you do not understand, read the booklet that comes with this form and the italicized instructions on the form, or ask your physician, other health care professional or an attorney for help. You may also review additional information and instructions concerning advance health care directives on the California Medical Association's website, www.cmanet.org. Internet access is available at your local public library.

1. APPOINTMENT OF HEALTH CARE AGENT

Option A. I, _____, wish to appoint a health care agent.
(Print your full name and date of birth)

If you choose to name an agent, check the box next to Option A, print your name and date of birth where indicated, then go to Page 2 and fill in the name and contact information of the person(s) (your agent and alternate agent(s)) you wish to make health care decisions for you if you are unable to make them for yourself. You may appoint alternate agents in case your first appointed agent is not willing, able or reasonably available to make these decisions when asked to do so.

Your agent may NOT be:

- A. Your primary treating health care provider.
- B. An operator of a community care or residential care facility where you receive care.
- C. An employee of the health care institution or community or residential care facility where you receive care, unless your agent is related to you or is one of your co-workers.

If you choose to name an agent, you should discuss your wishes with that person and give that person a copy of this form once completed. You should make sure that this person understands your wishes and the responsibility of being your agent for health care decisions, and is willing to accept that responsibility.

OR

Option B. I, _____, do not wish to appoint an agent at this time.
(Print your full name and date of birth)

If you choose not to name an agent, check the box next to Option B, print your name and date of birth where indicated, draw a line through the remainder of this Section, as well as through Section 2, then continue to Section 3.

I hereby appoint as my agent to make health care decisions for me:

Name (agent's name): _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone/Pager: (_____) _____ Fax: (_____) _____

I understand this appointment will continue unless I revoke it as explained in Section 3.

If I revoke my agent's authority or if my agent is not reasonably available, able or willing to make health care decisions for me, I appoint the following person(s) as my alternate agent(s) to make health care decisions for me, listed in the order they should be asked:

OPTIONAL: 1st alternate agent:

Name (agent's name): _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone/Pager: (_____) _____ Fax: (_____) _____

OPTIONAL: 2nd alternate agent:

Name (agent's name): _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone/Pager: (_____) _____ Fax: (_____) _____

2. AUTHORITY OF AGENT

Your agent must make health care decisions that are consistent with the instructions in this document and your known desires. It is important that you discuss your health care desires with the person(s) you appoint as your health care agent, and with your doctor(s). If your wishes are not known, your agent must make health care decisions that your agent believes to be in your best interest, considering your personal values to the extent they are known.

If my primary physician finds that I cannot make my own health care decisions, I grant my agent full power and authority to make those decisions for me, subject to any health care instructions set forth below. My agent will have the right to:

- A. Consent, refuse consent, or withdraw consent to any medical care or services, such as tests, drugs, surgery, or consultations for any physical or mental condition. This includes the provision, withholding or withdrawal of artificial nutrition and hydration (feeding by tube or vein) and all other forms of health care, including cardiopulmonary resuscitation (CPR).**
- B. Choose or reject my physician, other health care professionals or health care facilities.**
- C. Receive and consent to the release of medical information as permitted by HIPAA and the California Confidentiality of Medical Information Act.**
- D. Donate organs or tissues, authorize an autopsy and dispose of my body, unless I have said something different in a contract with a funeral home, in my will, or by some other written method.**

I understand that, by law, my agent may not consent to committing me to or placing me in a mental health treatment facility, or to convulsive treatment, psychosurgery, sterilization or abortion.

I understand that I can authorize my agent to begin making health care decisions for me:

- 1) Immediately upon full signature and witnessing of this document; or**

OPTIONAL: My signature in this box signifies that I want my agent's authority to make health care decisions for me to start now, **even though I am still able to make them for myself**. I understand and authorize this statement as proved by my signature here:

- 2) Only when I become unable to make such decisions for myself.**

OPTIONAL: My signature in this box signifies that I want my agent's authority to make health care decisions for me to start **only when I become unable to make such decisions for myself**. I understand and authorize this statement as proved by my signature here:

3. PRIOR DIRECTIVES REVOKED

I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration.

You may revoke any part of or this entire Advance Health Care Directive at any time. To revoke the appointment of an agent, you must inform your treating health care provider personally or in writing. Completing a new California Medical Association Advance Health Care Directive will revoke all previous directives. If you revoke a prior directive, notify every person, physician, hospital, clinic, or care facility that has a copy of your prior directive and, if you execute a new one, distribute copies of your new form to those persons or entities you then deem appropriate.

4. COPIES

My agent and others may use copies of this document as though they were originals.

Your agent may need this document immediately in case of an emergency. You should keep the completed original and give copies of the completed original to (1) your agent and alternate agents, (2) your physician(s), (3) members of your family and others who might be called in the event of a medical emergency, and (4) any hospital or other health facility where you receive treatment. Instruct your agent(s), family, and friends to provide a copy of your Directive to your physician(s) or emergency medical personnel on request.

5. HEALTH CARE INSTRUCTIONS

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 are 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 have a serious medical condition or terminal illness and have identified your specific health care wishes in a POLST form signed by your physician, you can make reference to your POLST below. If you do not wish to provide specific, written health care instructions in your Advanced Health Care Directive, 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 or life-sustaining treatments may include: medical devices put in you to help you breathe; food and fluid supplied artificially by medical device (IV/feeding tube); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; kidney dialysis; and antibiotics.

Sign either of the following general statements about life-support or life-sustaining treatments 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 on the next page, or on a separate sheet(s) of paper (one lined, separate sheet is included in this kit). You must date, sign, and attach any additional pages to this Directive.

If you have a fully executed POLST form that identifies your specific health care wishes, you may initial the last option indicating such.

OPTIONAL: If I am suffering from a terminal condition from which death is expected in a matter of months, or if I am suffering from an irreversible condition that renders me unable to make decisions for myself, and life-support or life-sustaining treatments are needed to keep me alive, then:

A. I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and that my physician(s) allows me to die as gently as possible. I understand and authorize this statement as proved by my signature here:

OR (cont. on next page)

B. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards. I understand and authorize this statement as proved by my signature here:

OPTIONAL: Other or additional statements of medical treatment desires and limitations:

OPTIONAL: I have added _____ page(s) of specific health care instructions to this Directive, each of which is signed and dated on the same day I signed this Directive.

OPTIONAL: I have a fully executed POLST dated _____ that identifies my specific health care wishes as indicated by my initials here: _____

For additional Advance Health Care Directive options, go to the California Medical Association's website at www.cmanet.org.

6. ORGAN AND TISSUE DONATION

I wish to be an organ and tissue donor. I understand and authorize this statement as proved by my signature here:

I have registered my decision to be a donor with Donate Life California Organ and Tissue Donor Registry through
 my driver's license and/or **signed up online www.donateLIFecalifornia.org**

**Only ID/DLs with donor designations issued after July 2006 have been added to the Donate Life California Registry. All ID/DLs issued prior to this date must register their decision online www.donateLIFecalifornia.org or at next ID/DL renewal.*

Organ and tissue donation represent one of the greatest gifts that an individual can make. A clear statement of your intent, such as the information that follows, will help to make sure that your intentions regarding organ and tissue donations are honored. Be sure to communicate these intentions to your family members, loved ones, and physician(s).

For more information on organ and tissue donation, contact Donate Life California at 866-797-2366 or at info@donatelifecalifornia.org.

OPTIONAL: Other or additional statements of organ and tissue donation desires and limitations.

I, _____, make this anatomical gift to take effect upon my death
(if solid organ or tissue donation is not possible):

I give

- my body
 - I have contacted and made arrangements with a hospital, or accredited medical school, or dental school, or college, or university.

Name of Institution: _____

- any part (e.g. organ, eye or tissue)
- only the following parts: _____

to

- any person in need of a transplant
- the following individual who will be the recipient of my donation _____

for

- transplantation or therapy
- medical education and research
- either of the above

I understand and authorize this statement as proved by my signature here: _____

7. DATE AND SIGNATURE OF PRINCIPAL

I sign my name to and acknowledge this Advance Health Care Directive:

(signature of principal) (date of birth) (date of signing)

OPTIONAL: Name and signature of adult signing Principal's name in Principal's presence and at Principal's direction:

(print name) (date) (signature)

8. STATEMENT OF WITNESSES

This Advance Health Care Directive will not be valid unless it is either: (1) signed by two qualified adult witnesses who are present when you sign or acknowledge your signature; or (2) 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 agent or alternate 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 or adoption, or 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: (1) sign as a witness; and (2) sign the Statement of Patient Advocate or Ombudsman that follows. You must also have a second qualified witness sign this Directive or have this document acknowledged before a notary public.

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 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) 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.

FIRST WITNESS:

Print Name: _____

Signature: _____

Date: _____ **Residence Address:** _____

SECOND WITNESS:

Print Name: _____

Signature: _____

Date: _____ **Residence 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 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

If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign the Statement of Witnesses 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 Probate Code 4675.

Print Name/Title: _____

Address: _____ Date: _____

Signature: _____

9. CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

Acknowledgment before a notary public is not required if two qualified witnesses have signed this Directive in Section 8. 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 in Section 8, even if you also have this form notarized.

State of California)
County of _____,)

On _____, before me, _____,

personally appeared _____, 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.

Signature _____ (Seal)

***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 5 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.

*Additional forms can be purchased from: CMA Publications, 1201 J Street, Suite 375, Sacramento, CA 95814-2905
Phone: 1-800-882-1262 • Fax: 916-551-2035 • Internet: www.cmanet.org.*

ADVANCE HEALTH CARE DIRECTIVE WALLET IDENTIFICATION CARD

These wallet cards are provided for the purpose of alerting emergency medical personnel that you have an Advance Health Care Directive in the event that you require medical treatment and are unable to talk. You should complete the cards by filling in the names and telephone numbers of your health care agent(s) or others who have a copy of your Advance Directive. Carry one of these cards with you at all times. Give the other to your spouse or other person who is likely to be contacted in the event of an emergency.

INSTRUCTIONS

1. On the top half of each card, print your full name and date of birth in the space provided.
2. On the lower half of each card, print the names and telephone numbers of the person(s) you have appointed as your health care agent and alternate agent(s) in the spaces provided. (Make sure the names and telephone numbers are the same as those listed in your Advance Health Care Directive form. Where the person has more than two phone numbers, use the numbers where the person is most likely to be reached in an emergency.) Space is also provided on the card to write in the name and telephone number(s) of a person who has a copy of your Advance Health Care Directive form. If you have not named alternate agents (or if you have not named an agent at all), you should list any other person who has a copy of your completed form. If more than three people have a copy, list the people who are most likely to be available by phone in the event of an emergency.
3. Carefully cut each card along the perforated lines, fold it in half, print sides showing, and place it in a conspicuous place in your wallet or billfold. Be sure to update the information on the card if there is a change in the telephone number(s) of any of the people you have listed on it, or if you subsequently complete a new Advance Health Care Directive form in which different individuals are designated to act as your agent and/or alternate agent(s).

IMPORTANT NOTICE TO EMERGENCY MEDICAL PERSONNEL

I, _____, born _____,
(name) (date of birth)

have executed an Advance Health Care Directive.

If I am unable to make my own health care decisions, my designated agent has the legal authority to make those decisions on my behalf including decisions concerning life-sustaining treatment. In such an event, one of the persons listed on the reverse of this card should be contacted immediately, in the order listed.

- I wish to be an organ donor I have a POLST form
 I have a pre-hospital Do Not Resuscitate (DNR) form

© California Medical Association 2009

FOLD HERE

1. Agent's Name: _____
Home: (_____) _____
Work/Cell/Pager: (_____) _____
2. Alt. Agent's/Friend's Name: _____
Home: (_____) _____
Work/Cell/Pager: (_____) _____
3. Alt. Agent's/Friend's Name: _____
Home: (_____) _____
Work/Cell/Pager: (_____) _____

IMPORTANT NOTICE TO EMERGENCY MEDICAL PERSONNEL

I, _____, born _____,
(name) (date of birth)

have executed an Advance Health Care Directive.

If I am unable to make my own health care decisions, my designated agent has the legal authority to make those decisions on my behalf including decisions concerning life-sustaining treatment. In such an event, one of the persons listed on the reverse of this card should be contacted immediately, in the order listed.

- I wish to be an organ donor I have a POLST form
 I have a pre-hospital Do Not Resuscitate (DNR) form

© California Medical Association 2009

FOLD HERE

1. Agent's Name: _____
Home: (_____) _____
Work/Cell/Pager: (_____) _____
2. Alt. Agent's/Friend's Name: _____
Home: (_____) _____
Work/Cell/Pager: (_____) _____
3. Alt. Agent's/Friend's Name: _____
Home: (_____) _____
Work/Cell/Pager: (_____) _____