

Durable Power of Attorney for Health Care

The Durable Power of Attorney for Health Care is an important legal document that you can use to appoint another person to make health care decisions for you if you become incapable of making them for yourself. You do NOT need a lawyer to complete this form. If you are at least 18 years of age and of sound mind, you are encouraged to discuss the creation of a Durable Power of Attorney for Health Care with your family, significant others and doctor. *The box below contains language required by California state law.*

Warning to Person Executing This Document

(California Probate Code Section 4703)

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

This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

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.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

This power is subject to any statement of your desires and any limitations that you include in this document.

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

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 by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (1) authorize an autopsy, (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Creation of a Durable Power of Attorney for Health Care. By completing this document you intend to create a durable power of attorney by appointing the person designated on the following page to make health care decisions for you, as allowed by the California Probate Code (§ 4600-4753). This power of attorney shall not be affected by your subsequent incapacity.

1. Designation of Health Care Agent. Your agent must be at least 18 years of age. The following may NOT be designated as your agent: (1) your treating health care provider (for example, your doctor or your hospital); (2) a non-relative employee of your treating health care provider; (3) an operator of a community care facility; (4) a non-relative employee of an operator of a community care facility; (5) an operator of a residential care facility for the elderly; or (6) a non-relative employee of an operator of a residential care facility for the elderly. For example, your agent may NOT be your doctor, your nurse or an employee of your nursing home UNLESS that person is a) related to you by blood, marriage or adoption, or b) employed by the same treating health care provider, community care facility, or residential care facility for the elderly that employs you. On the next page, fill in the name, address and telephone number of the person you wish to designate as your agent to make health care decisions for you.

I, _____, hereby appoint:
(print your name)

Name _____

Address _____ City _____ State _____

Home Telephone (____) _____ Work Telephone (____) _____ as my agent

to make health care decisions for me as authorized in this document. I understand that this power of attorney will be effective for an indefinite period of time unless I revoke it or limit its duration, as follows:

(optional) This power of attorney shall expire on the following date: _____

1a. Designation of Alternate Agent (optional). If the person named above is not available or willing to make health care decisions for me, I appoint the following person to do so:

First Alternate Agent Name _____

Address _____ City _____ State _____

Home Telephone (____) _____ Work Telephone (____) _____

2. Authority of Agent. If you are incapable of making decisions about your health care, you hereby grant to your agent full power and authority to make health care decisions for you, including: 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, and to receive and to consent to the release of medical information. And, in the event of your death, your agent may authorize an autopsy and arrange for the disposition of your remains. However, by law, your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, electroconvulsive treatment, psychosurgery, sterilization or abortion.

3. Medical Treatment Desires. Your agent must make health care decisions that are consistent with your known desires. You may, 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, which includes artificially provided nutrition and hydration. If you do not want your agent to have the authority to make certain decisions, you must 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 above in Paragraph 2. It is very important for you to discuss your health care desires with the person you appoint as your agent, as well as your doctor.

Initial Any or All of the Following Statements that Reflect Your Desires

I DO NOT want life sustaining treatment to be provided when:

_____ *the burdens of the treatment outweigh the expected benefits; therefore, I want my agent to consider the relief of suffering and quality of life when making decisions concerning the use of life-sustaining treatment*

_____ *I am terminally ill and the use of life-sustaining procedures would serve only to artificially prolong my life*

_____ *I am in an irreversible coma or persistent vegetative state*

Other or additional statements of medical treatment desires and/or limitations: _____

4. **Contribution of Anatomical Gift.** Pursuant to the Uniform Anatomical Gift Act, I hereby give, effective upon my death (please initial the statement that reflects your desires):

- Any needed organ or parts; or
- The parts or organs listed: _____
- No parts or organs, nor do I want my agent or family to consent.

(If you DO NOT initial any of the above statements, your agent and your family will have the authority to make a gift of all or part of your body under the Uniform Anatomical Gift Act.)

You Must Sign and Date this Durable Power of Attorney for Health Care

I sign my name to this Durable Power of Attorney for Health Care at _____, _____
 (city) (state)

on _____
 (date) (your signature)

5. **Statement of Witnesses.** This Power of Attorney will not be valid for making health care decisions unless it is 1) signed by two qualified adult witnesses who are present when you sign or acknowledge your signature (see below) OR 2) acknowledged before a notary public in California (see 6 on next page). None of the following may be used as a witness: 1) a person you designate as your agent, 2) your health care provider (for example, your doctor or hospital), 3) an employee of your health care provider, 4) the operator of a community care facility, 5) an employee of an operator of a community care facility, 6) the operator of a residential care facility for the elderly, or 7) an employee of an operator of a residential care facility for the elderly. For example, your witness may not be your doctor, nurse, hospital employee, nursing home employee, or operator of your board and care home. At least one of the witnesses cannot be related to you by blood, marriage or adoption, or be entitled to any portion of your estate under your existing will. **If you are a patient in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman (see 5b on next page).**

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, 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 the principal's health care provider, an employee of the principal'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.*

Signature _____	Signature _____
Print Name _____	Print Name _____
Date _____	Date _____
Residence Address _____	Residence Address _____

5a. 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 principal by blood, marriage, or adoption, and, to the best of my knowledge I am not entitled to any part of the principal's estate upon the principal's death under a will now existing or by operation of law.

Signature _____

5b. Special Requirement: 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 Witness on the previous page AND must sign the following declaration either 1) as one of the witnesses or 2) if this document is notarized, in addition to the notarization.

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 California Probate Code § 4701(e).

Signature _____

Print Name _____

Date _____

Residence Address _____

6. Certificate of Acknowledgement of Notary Public. You may use this certificate of acknowledgement before a notary public instead of the statement of witnesses. **You do NOT need to do both.**

State of California
County of _____ } SS.

On _____, before me, _____
(date) *(name and title of officer)*

personally appeared _____
(name of signer/principal)

personally known to me OR proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/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 of notary)

*Evidence for identification: 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.

COPIES: You should keep the completed, signed or notarized original document and give a photocopy to 1) your agent and to any alternate agents, 2) your doctor, 3) members of your family and 4) the health care facility when you are admitted. The photocopies of this document can be relied upon as though they were originals.

Terence A. Degan, M.D.
Family Practice Physician
1216 Suncast Lane Suite 1
El Dorado Hills, CA 95762

This Durable Power of Attorney for Health Care is provided to you by