This form has 3 parts. It lets you:

**Part 1: Choose a health care agent.**

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

**Part 2: Make your own health care choices.**

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

**Part 3: Sign the form.**

It must be signed before it can be used.

You can fill out Part 1, Part 2, or both. Fill out only the parts you want. Always sign the form in Part 3.

Go to the next page
What do I do with the form after I fill it out?

Share the form with those who care for you:
- doctors
- nurses
- social workers
- family
- friends

What if I change my mind?

- Change the form.
- Tell those that care for you about your changes

What if I have questions about the form?

- Bring it to your doctors, nurses, social workers, family or friends to answer your questions

What if I want to make health care choices that are not on this form?

- Write your choices on a piece of paper
- Keep the paper with this form
- Share your choices with those who care for you
PART 1 Choose your health care agent

The person who can make medical decisions for you if you are too sick to make them yourself.

Whom should I choose to be my health care agent?

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

Your agent cannot be your doctor or someone who works at your hospital or clinic, unless they are a family member.

What will happen if I do not choose a health care agent?

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.

If you want your agent to be someone other than family, you must write his or her name on this form.

What kind of decisions can my health care agent make?

Agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medications or tests
- what happens to your body and organs after you die

Go to the next page
Life support treatments - medical care to try to help you live longer

- **CPR or cardiopulmonary resuscitation**
  
  *cardio* = heart  
  *pulmonary* = lungs  
  *resuscitation* = to bring back

  This may involve:
  - pressing hard on your chest to keep your blood pumping
  - electrical shocks to jump start your heart
  - medicines in your veins

- **Breathing machine or ventilator**

  The machine pumps air into your lungs and breathes for you.
  
  You are not able to talk when you are on the machine.

- **Dialysis**

  A machine that cleans your blood if your kidneys stop working.

- **Feeding Tube**

  A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

- **Blood transfusions**

  To put blood in your veins.

- **Surgery**

- **Medicines**

End of life care - if you might die soon your health care agent can:

- call in a spiritual leader
- decide if you die at home or in the hospital

Show your health care agent this form.

Tell your agent what kind of medical care you want.
Part 1: Choose your health care agent

Your Health Care Agent

I want this person to help make my medical decisions

first name

last name

street address

city

state

zip code

(_____) – (_____) –

home phone number

work phone number

If the first person cannot do it, then I want this person to help make my medical decisions.

first name

last name

street address

city

state

zip code

(_____) – (_____) –

home phone number

work phone number

Put an X next to the sentence you agree with.

☒ My health care agent can make decisions for me now.

☒ My health care agent will make decisions for me only after I cannot make my own decisions.

To make your own health care choices go to part 2 on the next page.

To sign this form go to part 3 on page 9.
PART 2 Make your own health care choices

Write down your choices so those who care for you will not have to guess.

Think about what makes your life worth living.
Put an X next to all the sentences you most agree with.

☐ My life is only worth living if I can:
  ○ talk to family or friends
  ○ wake up from a coma
  ○ feed, bathe, or take care of myself
  ○ be free from pain
  ○ live without being hooked up to machines
  ○ I am not sure

☐ My life is always worth living no matter how sick I am

If I am dying, it is important for me to be:

☐ at home  ☐ in the hospital  ☐ I am not sure

Is religion or spirituality important to you?

☐ yes  ☐ no

What should your doctors know about your religion or spirituality?

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.
Part 2: Make your own health care choices

**Life support treatments** are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Put an X next to the sentences you most agree with.
Please read this whole page before you make your choices.

- **If I am so sick that I may die soon:**
  - Try all life support treatments that my doctors think might help.
    - If the treatments **do not work** and there is little hope of getting better, I **want to stay** on life support machines.
  - Try all life support treatments that my doctors think might help.
    - If the treatments **do not work** and there is little hope of getting better, I **do not want to stay** on life support machines.
  - Try all life support treatments that my doctors think might help **but not** these treatments. Mark what you do not want.
    - CPR
    - dialysis
    - breathing machine
    - feeding tube
    - blood transfusion
    - medicine
    - other treatments________________________________________
  - I **do not want any** life support treatments.
  - I want my **health care agent** to decide for me.
  - I am not sure.
Part 2: Make your own health care choices

Your doctors may ask about organ donation and autopsy after you die. Please tell us your wishes.

Put an X next to the sentences you most agree with

**Donating (giving) your organs can help save lives.**
- I want to donate my organs
  - Which organs do you want to donate?
    - any organs
    - only______________________________
  - I do not want to donate my organs.
  - I want my health care agent to decide.
  - I am not sure.

**An autopsy can be done after death to find out why someone died.**
It is done by surgery. It can take a few days.
- I want an autopsy.
- I do not want an autopsy.
- I may want an autopsy if there are questions about my death.
- I want my health care agent to decide.
- I am not sure.

**What should your doctors know about how you want your body to be treated after you die?**

Go to Part 3 on the next page to sign this form.
Before this form can be used, you must:

• sign this form.
• have two witnesses sign the form.

If you do not have witnesses, you need a notary public.
A notary public’s job is to make sure it is you signing the form.

Sign your name and write the date.

[ ] [ ] [ ]

sign your name date

print your first name print your last name

address city state zip code

Your witnesses must:

• be over 18 years of age.
• know you.
• see you sign this form.

Your witnesses cannot:

• be your health care agent, doctor, nurse, or social worker.
• benefit financially (get any money) after you die.
• work at the place that you live.
  (if you live in a nursing home, go to page 12)

Only one witness can be a family member.
The second witness must be someone other than family.

Witnesses need to sign their names on the next page.

If you do not have witnesses, take this form to a notary public
and have them sign on page 11.
**Part 3: Sign the form**

<table>
<thead>
<tr>
<th>Witness #1</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>sign your name</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>print your first name</td>
<td>print your last name</td>
<td></td>
</tr>
<tr>
<td>address</td>
<td>city</td>
<td>state</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Witness #2</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>sign your name</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>print your first name</td>
<td>print your last name</td>
<td></td>
</tr>
<tr>
<td>address</td>
<td>city</td>
<td>state</td>
</tr>
</tbody>
</table>

You are now done with this form.

Share this form with your doctors, nurses, social workers, friends, and your family.

Talk with them about your choices.
NOTARY PUBLIC

- Take this form to a notary public **ONLY** if two witnesses have not signed this form.
- Bring photo I.D. (driver’s license, passport, etc.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC
STATE OF CALIFORNIA

County of__________________________________________________________

On this_______day of______________in the year__________________before me
(__________________________________________________________)
(print name of notary public)

personally appeared____________________________________________________
(print name of person completing this form)

and has proved to me on the basis of satisfactory evidence, to be the person whose name is
indicated on this advance health care directive, and has stated that he or she did complete
this form. I declare under penalty of perjury, that the person, whose name is indicated in
the advance health care directive, appears to be of sound mind and is under no duress,
fraud, or undue influence.

NOTARY SEAL

____________________________________________
(Signature) (Date)

You are now done with this form.

Share this form with your doctors, nurses, social workers, friends, and your family.

Talk with them about your choices.
California Advance Health Care Directive

For California Nursing Home Residents ONLY

- Give this form to your nursing home director only if you live in a nursing home.
- California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

STATEMENT OF THE 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.”

/ / 
sign your name date

print your first name print your last name

address city state zip code