California Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you get very sick.

This form has 3 parts. It lets you:

Part 1: Choose a medical decision maker, Page 3

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

Part 2: Make your own health care choices, Page 6

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, Page 11

The form 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.

2 witnesses need to sign on Page 12, or a notary on Page 13.

Your Name

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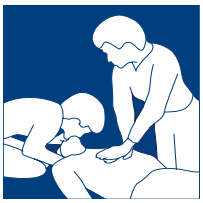
Here are more decisions your medical decision maker can make:

Start or stop life support treatments, such as:



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

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

- **Breathing machine or ventilator**
  The machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.
- **Dialysis**
  A machine that tries to clean your blood if your kidneys stop working.

- **Feeding Tube**
  A tube used to try 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 and water transfusions**
  To put blood and water into your body.
- **Surgery**
- **Medicines**

End of life care – if you might die soon your medical decision maker can:

- call in a spiritual leader
- decide if you die at home or in the hospital
- decide about an autopsy and organ donation
- decide where you will be buried or cremated

If I sign this form, it will be okay for my medical decision maker to agree to, refuse, or withdraw any of these or other treatments.

If there are decisions I do not want them to make, I will write them here:

Your Name

Your Medical Decision Maker

I want this person to make my medical decisions if I cannot make my own

first name _____ last name _____

phone #1 _____ phone #2 _____ relationship _____

address _____ city _____ state _____ zip code _____

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

first name _____ last name _____

phone #1 _____ phone #2 _____ relationship _____

address _____ city _____ state _____ zip code _____

When can my medical decision maker make decisons for me?

They can make decisions for me:

- ◯ ONLY after I become too sick and cannot make my own decisions.
- ◯ NOW, right after I sign this form.

How do you want your medical decision maker to follow your healthcare wishes?

Put an X next to the one sentence you most agree with.

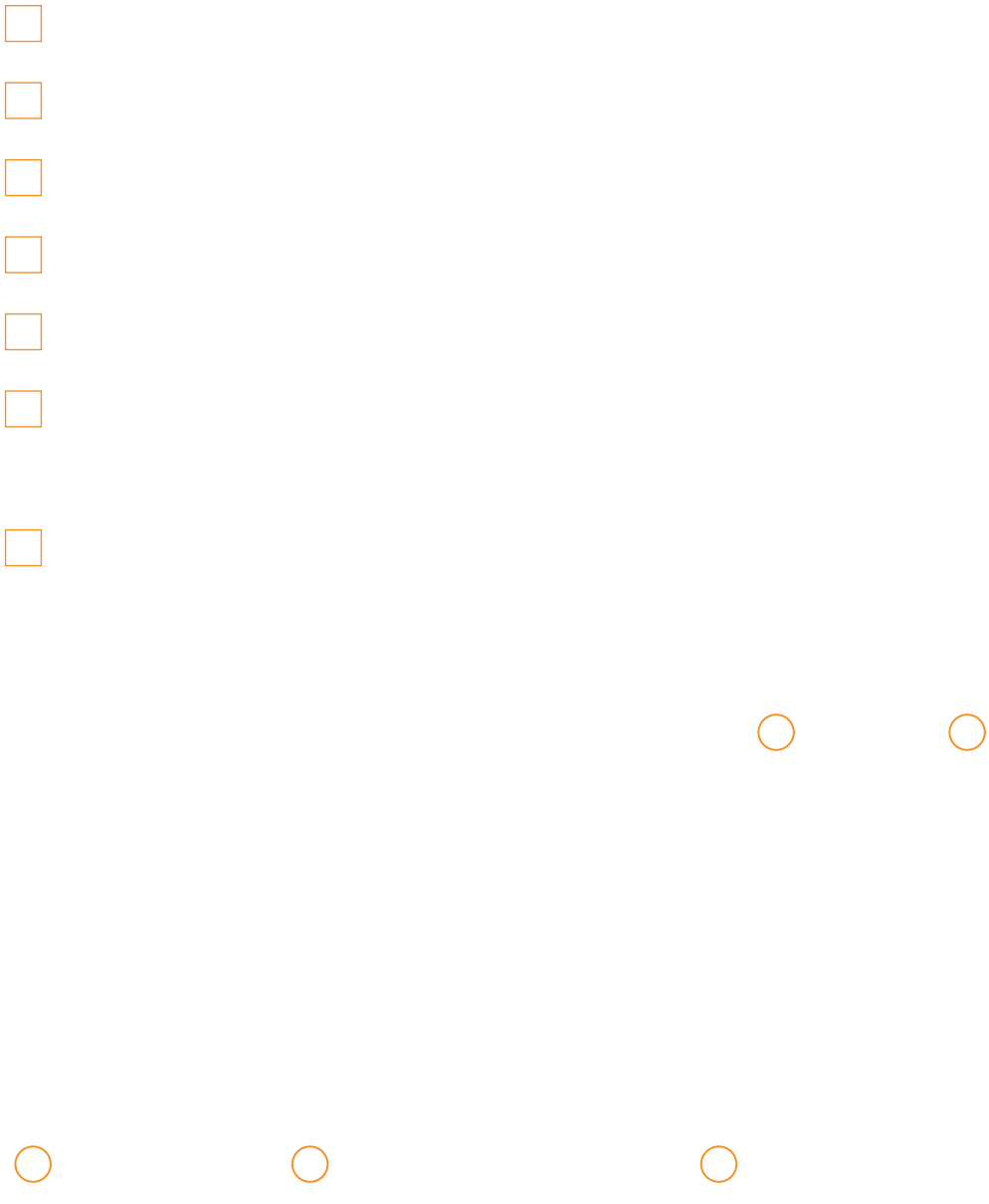
- ◯ **Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- ◯ **Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these are some wishes I NEVER want changed:

  _____

  _____

- ◯ **No flexibility:** I want my decision maker to follow my medical wishes exactly, no matter what. It is NOT OK to change my decisions, even if the doctors recommend it.

To make your own health care choices go to Part 2 on Page 6.
If you are done, you must sign this form on Page 11.



Have your witnesses sign their names and write the date.

By signing, I promise that _____ signed this form.
(name of the person signing this form)

They were thinking clearly and were not forced to sign it.

I also promise that:

- I know this person and they could prove who they were.
- I am 18 years of age or older
- I am not their medical decision maker
- I am not their health care provider
- I do not work for their health care provider
- I do not work where they live

One witness must also promise that:

- I am not related to them by blood, marriage, or adoption
- I will not benefit financially (get any money or property) after they die

Witness #1

_____ _____
sign your name date

_____ _____
print your first name print your last name

_____
address city state zip code

Witness #2

_____ _____
sign your name date

_____ _____
print your first name print your last name

_____
address city state zip code

You are now done with this form.

Share this form with your family, friends, and medical providers. Talk with them about your medical wishes. To learn more go to www.prepareforyourcare.org.

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Notary Public: Take this form to a notary public ONLY if two witnesses have not signed this form. Bring photo ID (driver's license, passport, etc.).

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of _____

On _____ (Date) before me, _____ (Here insert name and title of the officer) , personally appeared _____ (Names(s) of Signer(s))

_____

who proved to me 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 _____ (Signature of Notary Public)

Description of Attached Document

Title or type of document: _____

Date: _____ Number of pages: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____

○ Individual
○ Guardian or conservator
○ Other _____

RIGHT THUMBPRINT OF SIGNER

Top of thumb here

(Notary Seal)

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 _____

To learn more, go to www.prepareforyourcare.org

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