STRUCTIONS

INT YOUR NAME

INT THE

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LEPHONE
MBERS OF YOUR
ENT

INT THE NAME,
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1. HEALTH CARE POWER OF ATTORNEY

I, _____, as principal,
(name)

designate

_____
(name of agent)

_____
(address)

_____(home telephone number)

_____(work telephone number)

as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint

_____
(alternate agent)

_____
(address)

_____(home telephone number)

_____(work telephone number)

as my agent.

INSTRUCTIONS

INITIAL THE STATEMENT THAT APPLIES IN EACH PARAGRAPH

I have _____ I have not _____ completed the living will (Part 2 of the Health Care Directive form) for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the living will.

I have _____ I have not _____ completed a prehospital medical care directive pursuant to section 36-3251, Arizona Revised Statutes.

Note: A prehospital medical care directive must be in the form required by the Arizona Department of Health Services, and must be signed by you, your physician, and a witness. A form can be found online at http://www.azag.gov/life_care/. We suggest you speak to your physician for more information. Caring Info does not distribute these forms.

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2. LIVING WILL (OPTIONAL)

Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully before you initial your selection. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care under the section titled "Other or additional statements of desires." **You may initial any combination of paragraphs 1, 2, 3 and 4 but if you initial paragraph 5 the others should not be initialed.**

INITIAL ANY AND ALL PARAGRAPHS THAT REFLECT

YOUR WISHES AND CROSS THROUGH STATEMENTS THAT DO NOT REFLECT YOUR WISHES

_____1. If I have a terminal condition I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care (treatment given to protect and enhance my quality of life), that would serve only to artificially delay the moment of my death.

_____2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following

- cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing; or
- artificially administered nutrition and hydration; or
- to be taken to a hospital if at all avoidable.

_____3. Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

YOU MAY ADD ADDITIONAL

STATEMENTS THAT REFLECT YOUR WISHES ON THE NEXT PAGE

_____4. Notwithstanding my other directions I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____5. Regardless of my condition, I want my life to be prolonged to the greatest extent possible.

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Other or additional statements of desires:

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INSTRUCTIONS

AUTOPSY (OPTIONAL)

IF YOU CHOOSE TO INITIAL A STATEMENT, INITIAL ONLY ONE STATEMENT THAT REFLECTS YOUR WISHES

3. AUTOPSY (Optional)
(UNDER ARIZONA LAW AN AUTOPSY MAY BE REQUIRED IN CERTAIN CIRCUMSTANCES)

If one of the statements below reflects your wishes, initial on the line next to that statement. If you choose to initial a statement, initial only one statement. You do not have to initial any of the statements.

_____ 1. I do not consent to an autopsy in any situation in which an autopsy is not otherwise required by law.

_____ 2. I consent to an autopsy.

_____ 3. My agent may give consent to or refuse an autopsy.

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4. ORGAN DONATION (OPTIONAL)

(Under Arizona law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law. The donation elections you make below survive your death.)

If any of the statements below reflects your desire, initial on the line next to that statement. You do not have to initial any of the statements. If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Arizona law.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

_____ Pursuant to Arizona law, I hereby give, effective on my death:
_____ Any needed organ or parts.
_____ The following part or organs listed below:

for (initial one):
_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

PHYSICIAN AFFIDAVIT (OPTIONAL)

YOUR DOCTOR SHOULD COMPLETE THIS SECTION

5. PHYSICIAN AFFIDAVIT (OPTIONAL)

(Before initialing any choices in your Health Care Directive you may wish to ask questions of your physician regarding a particular treatment alternative. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his or her file.)

I, Dr. _____,
have reviewed this guidance document and have discussed with

_____
any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on _____.
(date)

I have agreed to comply with the provisions of this directive.

_____
(signature of physician)

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FUNERAL AND BURIAL DISPOSITION (OPTIONAL)

INITIAL THE STATEMENTS THAT REFLECT YOUR WISHES

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6. FUNERAL AND BURIAL DISPOSITION (OPTIONAL)

If any of the statements below reflects your desire, initial on the line next to that statement. You do not have to initial any of the statements.

My agent has authority to carry out all matters relating to my funeral and burial disposition wishes in accordance with this power of attorney, which is effective upon my death. My wishes are as follows:

_____ Upon my death, I direct my body to be buried (as opposed to cremated).

_____ Upon my death, I direct my body to be buried in _____.

_____ Upon my death, I direct my body to be cremated.

_____Upon my death, I direct my body to be cremated, with my ashes to be _____ .

_____ My agent may make all funeral and burial disposition decisions.

EXECUTION

This Health Care Directive will not be valid unless it is EITHER:

IF YOU CHOOSE TO SIGN WITH A WITNESS, USE ALTERNATIVE 1, BELOW

(A) Signed by at least one qualified adult witness who is present when you sign and who affirms that you appear to be of sound mind and are under no duress. The witness cannot be related to you by blood, marriage, or adoption, entitled to any part of your estate at the time the document is signed, appointed as your agent, or involved with the provision of your health care at the time the document is signed. (Use Alternative 1, below, if you decide to have your signature witnessed.)

OR

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW

(B) Witnessed by a notary public who is neither your agent nor a person involved with the provision of your health care at the time the document is signed. The notary must also affirm that (a) he/she was present when you dated and signed the document, (b) you appeared to be of sound mind and free from duress at the time you signed the document. (Use Alternative 2, below, if you decide to have your signature notarized.)

NOTE: If the principal is physically unable to sign the Health Care Direct ive, the witness or notary must add a statement that "The principal has directly indicated to me that this Helth Care Directive expresses his or her wishes and that the principal intends to adopt this Health Care Direct ive at this time."

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INSTRUCTIONS

SIGN AND DATE THE DOCUMENT

WITNESSING PROCEDURE

WITNESS MUST SIGN AND PRINT HIS OR HER ADDRESS

WITNESS MUST SIGN THIS STATEMENT IF PRINCIPAL IS PHYSICALLY UNABLE TO SIGN

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OPTION 1: Sign before a Witness

This health care directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

_____
(signature of principal)

_____ _____
(date) (time)

I affirm that this was signed or acknowledged and dated in my presence, and that the person signing this document (the principal) appears to be of sound mind and under no duress. I am not designated to make medical decisions on the principal's behalf. I am not directly involved with the provision of health care to the principal. I am not entitled to any portion of the principal's estate upon his or her decease, whether under any will or by operation of law. I am not related to the principal by blood, marriage, or adoption.

Witness: _____ Date:_____

Address: _____

_____

Note: If the principal is physically unable to sign the Health Care Directive, the Witness must sign the following statement:

> The principal has directly indicated to me that this Health Care Directive expresses his or her wishes and that the principal intends to adopt this Health Care Directive at this time.

Witness: ___ Date:_____

INSTRUCTIONS

SIGN AND DATE THE DOCUMENT

NOTARY WILL FILL OUT THIS PART OF THE FORM

NOTARY MUST SIGN THIS STATEMENT IF PRINCIPAL IS PHYSICALLY UNABLE TO SIGN

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OPTION 2: Sign Before a Notary

This health care directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

_____
(signature of principal)

_____ _____
(date) (time)

State of Arizona
County of _____

The foregoing instrument was signed or acknowledged before me this _____ day of _____, _____, by

_____ (principal).

The person signing this document (the principal) appears to be of sound mind and is under no duress. I am not designated to make medical decisions on the principal's behalf. I am not directly involved with the provision of health care to the principal.

_____
NOTARY PUBLIC
Print Name: _____

My Commission Expires:

Note: If the principal is physically unable to sign the Health Care Directive, the Notary must sign the following statement:

> The principal has directly indicated to me that this Health Care Directive expresses his or her wishes and that the principal intends to adopt this Health Care Directive at this time.

Notary: _____ Date: _____