ADVANCE HEALTH CARE DIRECTIVE

OF

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ADVANCE HEALTH CARE DIRECTIVE
INCLUDING DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(California Probate Code Sections 4600 - 4805)

WARNING TO PERSON EXECUTING THIS DOCUMENT

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 as long as you can give informed consent. 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.

ADVANCE HEALTH CARE DIRECTIVE

Including Durable Power of Attorney for Health Care Decisions
California Probate Code Sections 4600-4805

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 6). If there is anything in this form you do not understand, read the italicized instructions, or ask your physician, other health care professional, or an attorney for help.

1. APPOINTMENT OF HEALTH CARE AGENT

Option A. I, Abigail Adams, born June 20, 1730, wish to appoint a health care agent.

_____
(*Signature of Principal*)

Fill in below 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:*

1. *Your primary treating health care provider.*
2. *An operator of a community care or residential care facility where you receive care.*
3. *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. You should make sure that this person understands your wishes and this responsibility and is willing to accept it.

I hereby appoint as my health care agent, who will make health care decisions for me:

Agent's Name: Richard Adams
Address: 64 Cowell Blvd., Walnut Creek, California 94521
Home Phone:

OPTIONAL: 1st Alternate health care agent: Kathleen Adams
Address: 4567 Drangonfly, Woodinville, Washington 98072
Home Phone:

OPTIONAL: 2nd Alternate health care agent: Kenneth Adams
Address: 3654 Roses Blvd., Seattle, Washington 98119
Home Phone: 206-281-2405

OR

Option B. I, Abigail Adams, born June 20, 1730, do **not** wish to appoint a health care agent.

_____
(*Signature of Principal*)

If you choose not to name an agent, fill out Option B above, leave the line at Option A blank, and if you prefer, for the sake of clarity, you may draw a line through the rest of this Section 1 and all of Section 2. Your failure to draw a line though Section 1 and 2 does not invalidate your decision not to name an agent.

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.
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.

OPTIONAL. I want my health care 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 immediately below:

_____.
(*Signature of Principal*)

3. NOMINATION OF CONSERVATOR

If proceedings are initiated for the appointment of a conservator of my person, I nominate Richard Adams as conservator of my person. If Richard Adams is unable or unwilling to act as

conservator of my person, I nominate Kathleen Adams as conservator of my person. If Kathleen Adams is unable or unwilling to act as conservator of my person, I nominate Kenneth Adams as conservator of my person.

4. STATEMENT OF AUTHORITY REGARDING MEDICAL RECORDS AND COMMUNICATIONS WITH HEALTH CARE PROVIDERS

A. I hereby grant my agent or conservator the same rights as I have to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information, including but not limited to treating physicians' reports, radiology scans and reports, surgeons' notes, pathology reports, laboratory reports, daily progress notes and status, doctors' orders, prescription and pharmacy orders, daily status reports, emergency room reports, and infectious disease reports, pursuant to California Probate Code Section 4678. In granting this authority, I hereby waive my rights to privacy and protections granted under the California Constitution, all state or federal decisional or statutory laws, and the federal Health Insurance Portability and Accountability Act (HIPAA) with respect to any information requested by my agent or conservator.

_____
(*Signature of Principal*)

B. I refuse to grant my agent any of the above listed rights to access my personal medical or other health care information.

_____
(*Signature of Principal*)

5. PRIOR DIRECTIVES REVOKED

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

You may revoke any part of 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 in writing. Completing a new 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 give them a copy of your new directive, if you execute one.

6. HEALTH CARE INSTRUCTIONS CONCERNING MEDICAL TREATMENT

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 do not wish to provide specific, written health care instructions, leave the below lines blank or 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 treatments may include: medical devices put in you to help you breathe; food and fluid supplied artificially by medical device (feeding tube); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; kidney dialysis; and antibiotics.

Sign either of the following general statements about life-support 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 this in the space provided or on a separate sheet of paper which you must date and sign and attach to this form.

OPTIONAL STATEMENTS. The statement I have signed below is to apply **if I need life-support treatments** to keep me alive.

A. If my primary care physician reasonably believes that I am (1) in an irreversible **coma** or

a persistent condition that will render me **unconscious for the rest of my life**, ***or*** (2) I am suffering from a **terminal condition** (from which death is expected in a matter of six months or less if the illness or condition runs its natural course), **I do not want life-support treatments to be provided or continued**, **but only palliative care** (treatments needed to keep me comfortable, and without severe pain). I understand and authorize this statement as proved by my signature immediately below:

_____
(*Signature of Principal*)

OR

B. If my primary care physician reasonably believes that I am in an **irreversible coma** or a

persistent condition that will render me **unconscious for the rest of my life**, **I do not want life-support treatments to be provided or continued**. **Otherwise I want my life prolonged by life-support treatments**. I understand and authorize this statement as proved by my signature immediately below:

_____
(*Signature of Principal*)

OR

C. **I want my life to be prolonged as long as possible without regard to my condition or**

the anticipated length of my life. I understand and authorize this statement as proved by my signature immediately below:

_____
(*Signature of Principal*)

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.

7. 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.

8. ORGAN AND TISSUE DONATION

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

_____
(*Signature of Principal*)

I have indicated this on my driver's license and/or optional section below or an attached page.

*If you **do not** wish to be an organ donor, please check this box , or you may leave the line immediately above this sentence empty, or you may draw a line through this Section 8 and initial it.*

***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).*

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

I make this anatomical gift effective upon my death.

_____
(*Signature of Principal*)

I choose **to give**

my body

any needed organ (e.g., kidneys, liver, heart, lungs, pancreas, spleen), tissue (corneas, heart valves, skin, bone) or parts

only the following organs, tissues, or parts: _____

_____

to

the regional organ procurement agency or eye or tissue bank for transplantation or other therapy

the following university, hospital, storage bank, or other medical institution:

_____

for

transplantation or treatment of any person who can medically benefit

medical education

medical research

any purpose authorized by law

I understand and authorize the above statements as proved by my signature below

_____
(*Signature of Principal*)

9. AUTOPSY

I understand that my agent will be able to authorize an autopsy (an examination of my body after my death to determine the cause of my death) unless I limit that authority in this document. If you do not want your agent to be involved in these matters, you should state your desires concerning an autopsy. Sign next to the statement below that reflects your desire. Under some circumstances, the law may require that an autopsy be performed even if you have refused to authorize your agent to consent to one.

A. I hereby consent to my agent authorizing an examination of my body after my death to

determine the cause of my death.

_____
(*Signature of Principal*)

B. My agent may NOT authorize an autopsy.

_____
(*Signature of Principal*)

10. DISPOSITION OF MY REMAINS

I understand that my agent will be able to direct the disposition of my remains unless I limit that authority in this document. I also understand that my agent or any other person who directs the disposition of my remains must follow any instructions I have given in a written contract for funeral services, my will, or by some other method.

If you do not want your agent to be involved in these matters, you should state your desires concerning the person you would like to direct the disposition of your remains. If any of the statements below reflect your desires, sign next to that statement.

A. I prefer that my agent direct the disposition of my remains by the following method (check one):

burial cremation

_____
(*Signature of Principal*)

B. My agent may **NOT** direct the disposition of my remains and I would prefer that the person I name below direct the disposition of my remains.

Name: _____
Address: _____

_____
(*Signature of Principal*)

C. I have described the way I want my remains disposed of in (check one):

A written contract for funeral services with (name of

mortuary/cemetery/organization)

Name: _____
Address: _____

My Will

Other

_____
(*Signature of Principal*)

11. DATE AND SIGNATURE OF PRINCIPAL

I sign my name and acknowledge this Advance Health Care Directive,

_____
(Signature of Principal)

on this date_____. I was born on _____
(Date of Signing) *(Date of Birth)*

12. STATEMENT OF TWO WITNESSES OR NOTARY PUBLIC

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.

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 sign as a witness below and sign the following Statement of Patient Advocate or Ombudsman. You must also have a second qualified witness sign below or in the alternative, have this document acknowledged before a notary public.

A. STATEMENT OF TWO WITNESSES

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.*

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 (* see page 10), (2) that the individual signed or acknowledged this Advance Heath 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. **If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign as a witness below, regardless of whether this document is acknowledged before a notary public (in which case you do not need a second witness).**

First Witness: _____ _____
(*Name:_____*) *(Date Signed)*

Residence Address: _____

Second Witness: _____ _____
(*Name:_____*) *(Date Signed)*

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.

Additional Declaration by a Witness:

_____ _____
(Name:_____) (*Date Signed)*

Residence Address: _____

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN (For a Patient in a Skilled Nursing Home)

I further declare under penalty of perjury under these 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.

Name Printed: _____ Title Printed: _____

Date: _____ Address: _____

AND/OR

B. CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

Acknowledgment before a notary public is not required if two qualified witnesses have signed on page 9. If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign the Statement of Witnesses on page 9 and the Statement of Patient Advocate or Ombudsman above, even if you also have this form notarized.

State of California)
) ss
County of Contra Costa)

On this _____, before me, _____, Notary Public
(Date) (Name and Title of Officer)

personally appeared _____,

personally known to me (or 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 this instrument.

WITNESS my hand and official seal.

Notary Seal

_____
John C. Harrison, Comm. No. 1516511, Expires September 30, 2008
Contra Costa County County, Stamp Manu. NNA1, (925) 906-1880

_____

*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 care 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.

LAWYER'S CERTIFICATE

I am a lawyer authorized to practice law in the state where this power of attorney was executed, and the principal was my client at the time this power of attorney was executed. I have advised my client concerning my client's rights in connection with this power of attorney and the applicable law and the consequences of signing or not signing this power of attorney, and my client, after being so advised, has executed this power of attorney.

Dated: April 16, 2007

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