COMBINED LIVING WILL AND ADVANCE HEALTHCARE DIRECTIVE

State of residence: CA **Place of paper signing:** CA **Effective Date:** [DATE]

I, **[DECLARANT NAME]**, born [DATE], residing at [DECLARANT ADDRESS] (the "Declarant," "Principal," or "Patient"), being of sound mind and at least eighteen (18) years of age, voluntarily make this **Combined Advance Healthcare Directive** — comprising a **Living Will** (statement of treatment wishes) and a **Healthcare Power of Attorney** (appointment of a healthcare agent) — under the laws of the State of CA, as a directive to physicians, my healthcare agent, family members, and all other persons concerned with my care.

1. Statement of Capacity and Voluntariness

I am competent to make this directive. I understand its contents and legal effect. I am not acting under duress, fraud, or undue influence. I make this directive freely and voluntarily, after reflection on the medical, personal, moral, and (where applicable) religious implications of the choices expressed herein.

2. Appointment of Healthcare Agent

I hereby appoint the following person as my Healthcare Agent (the "Agent") to make healthcare decisions for me if I lose the capacity to make them myself:

- **Name:** [PRIMARY AGENT FULL LEGAL NAME]
- **Relationship:** [RELATIONSHIP TO YOU]
- **Address:** [PRIMARY AGENT ADDRESS]
- **Phone:** [PRIMARY AGENT PHONE]

First Alternate Agent (serves if the primary Agent is unavailable, unwilling, or unable):

- **Name:** [ALTERNATE AGENT FULL LEGAL NAME RECOMMENDED]
- **Address:** [ALTERNATE AGENT ADDRESS]
- **Phone:** [ALTERNATE AGENT PHONE]

Second Alternate Agent (serves if both prior Agents are unavailable):

- **Name:** [SECOND ALTERNATE AGENT FULL LEGAL NAME]
- **Phone:** [SECOND ALTERNATE AGENT PHONE]

When authority begins. My Agent's authority begins when a physician determines in writing that I lack the capacity to make or communicate my own healthcare decisions, and ends when I regain capacity.

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Scope of authority. My Agent has full authority to make all healthcare decisions I could make if I had capacity, including (without limitation): consenting to, refusing, or withdrawing any medical treatment, service, or procedure; selecting, hiring, and discharging physicians, nurses, therapists, and facilities; authorizing or refusing artificial nutrition, hydration, and life-sustaining treatment (consistent with any explicit instructions in this directive); obtaining medical information relevant to an authorized decision; making decisions about pain management, palliative sedation, hospice, and comfort care; admitting me to or discharging me from hospitals, nursing homes, assisted-living facilities, and hospice programs; authorizing an autopsy; directing disposition of my remains; and making an anatomical gift of my body or parts thereof consistent with any instruction below.

Agent obligation. My Agent shall make decisions consistent with my wishes as stated in this directive. Where my wishes are unknown or do not clearly address a specific circumstance, my Agent shall act in my best interest after consulting with my attending physician and weighing the burdens and benefits of treatment.

Ineligible persons. My Agent is not my attending physician, an employee of my attending physician, or an owner/operator/employee of a residential healthcare facility where I reside (unless related to me by blood, marriage, or adoption).

Nomination of guardian/conservator. If a court proceeding is ever initiated to appoint a guardian or conservator of my person, I nominate my Agent (and the alternates, in order) to serve in that capacity, to the maximum extent permitted by law.

3. Statement of Treatment Wishes (Living Will)

Treatment choices. A blank or unselected item states no preference on that item. It is not consent, refusal or a medical order. Where a specific instruction applies, it takes priority over a general goal. A choice about ventilation does not choose CPR for me.

Overall philosophy. No specific instruction.

Conditions under which this directive applies. This directive takes effect if I am unable to make or communicate healthcare decisions and my attending physician (or, where required, two physicians) determines that I am in any of the following conditions:

Specific Treatment Instructions

Artificial Nutrition and Hydration (feeding tubes, IV fluids) — initial _____. No specific instruction.

Cardiopulmonary Resuscitation (CPR). No specific instruction.

Mechanical Ventilation. No specific instruction.

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Dialysis. No specific instruction.

Antibiotics. No specific instruction.

Blood Transfusions. No specific instruction.

Emergency care and travel. These are personal instructions, not an emergency medical order. Review emergency orders with an authorized clinician for the setting where I receive care. When I travel or transfer, my care team should check the destination's requirements.

4. Pregnancy

No specific instruction.

5. Agent access to decision-related records

When my Agent has legal authority to make a healthcare decision for me, the Agent may obtain information relevant to that authority under 45 C.F.R. § 164.502(g), subject to applicable exceptions. Appointment alone is not blanket permission to disclose my records. Separate consent may be needed for specially protected records.

9. Preferred Setting for Care

I express no specific preference regarding care setting; my Agent and care team may decide based on the circumstances.

10. Personal Message to My Loved Ones and Caregivers

[PERSONAL MESSAGE TO LOVED ONES AND]

11. Revocation

I may revoke this directive at any time and in any manner that communicates my intent to revoke, regardless of my mental or physical condition. Methods of revocation include: (a) a signed and dated written revocation; (b) physical destruction of this directive with intent to revoke; (c) an oral statement of revocation made to my Agent or to a healthcare provider; or (d) the execution of a subsequent directive that, in whole or in part, supersedes this one.

12. Effect of Copy

A copy of this executed directive has the same force and effect as the signed original. I authorize my Agent, physicians, hospitals, and family members to rely on a photocopy, scan, facsimile, or electronic copy of this document.

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13. Severability and Governing Law

If any provision of this directive is held invalid or unenforceable, the remaining provisions shall continue in full force and effect. This directive shall be governed by the laws of the State of CA, provided that it shall also be given effect in any other jurisdiction to the extent permitted by that jurisdiction's law.

Patient Self-Determination Act Notice

Under the federal Patient Self-Determination Act of 1990 (42 U.S.C. §§1395cc(f), 1396a(w)), hospitals, nursing homes, home health agencies, hospices, and HMOs participating in Medicare or Medicaid are required to ask adult patients whether they have an advance directive, to provide information about advance directives, and to not discriminate in care based on the existence or non-existence of a directive.

See the California paper signing instructions below.

State Advance-Directive Registry

The State of CA operates an advance-directive registry. I may elect to register this directive with the state so that healthcare providers can retrieve it electronically. Registration is optional and does not affect validity.

Signature of Declarant

I sign this directive knowingly, voluntarily, and after careful consideration.

Declarant

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Paper signing location. CA. If the place of signing and the place of care differ, check the rules for both. The residence entry does not establish where this document was signed.

California paper signing

Date and sign this directive, or have another adult sign your name in your presence and at your direction. If signing outside California, this is the California-law route; ask about local execution if you intend to use the law of the place of signing instead. This page describes paper execution under California Probate Code §§4673–4675. Residence and place of signing may differ. California recognizes a written directive made elsewhere under the law of the place of execution or under California law (§4676). For use outside California, check the receiving jurisdiction’s rules.

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Two adult witnesses

Each adult witness must personally observe the signing or acknowledgment and sign the following declaration. Do not use an appointed agent or a disqualified provider, facility operator, or employee.

I declare under penalty of perjury under the laws of California that I personally know the individual or the individual's identity was proven to me by convincing evidence; the individual signed or acknowledged this directive in my presence; and the individual appears of sound mind and free of duress, fraud, or undue influence. I am not an agent named in this directive, the individual's health care provider or an employee of that provider, the operator or an employee of the operator of a community care facility, or the operator or an employee of the operator of a residential care facility for the elderly.

First adult witness — printed name: _____

Signature: _____ Date: _____ Address: _____

Second adult witness — printed name: _____

Signature: _____ Date: _____ Address: _____

Additional declaration — at least one of the two witnesses signs here. I further declare under penalty of perjury under California law that I am not related to the individual by blood, marriage, or adoption and, to the best of my knowledge, I am not entitled to any part of the individual's estate at death under a will now existing or by operation of law.

Qualifying witness — printed name: _____ Signature: _____ Date: _____

Special witness for a skilled nursing facility patient

You indicated that you expect to sign as a skilled nursing facility patient. Arrange for the designated witness before signing. A patient advocate or ombudsman designated for this purpose by the California Department of Aging must witness and sign. On the two-witness route the designated person is one of the two qualified witnesses and also signs this declaration. On the notarized route the designated witness signs in addition to notarization. Notarization alone does not meet this requirement.

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman designated by the State Department of Aging and that I am serving as the witness required by Probate Code §4675.

Designated witness — printed name: _____

Signature: _____ Date: _____

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Address, city and state: _____

Distribution

This directive shall be distributed to, at minimum: (a) my primary-care physician; (b) my healthcare Agent and any alternate Agents; (c) the hospital or healthcare facility where I typically receive care; (d) close family members; and (e) if applicable, my state's advance-directive registry.

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