Advance Directive Packet

This packet is provided as a courtesy by JacksonWhite Elder Law Attorneys. It is not intended to be legal advice. If you do not understand the forms in the packet, or their implications, please contact an attorney before signing. *For more information or to request more packets, please contact JacksonWhite Elder Law at (800)243-1160.*

Health Care Power of Attorney:

- Allows the principal to name an agent and a secondary agent, who are authorized to make medical and long-term care decisions if the principal loses capacity.
- Must either be signed by the principal in the presence of a witness, or
- Can be signed by the principal in the presence of a notary.

Mental Health Care Power of Attorney:

- Allows the principal to name an agent and a secondary agent, who are authorized to make mental health treatment related decisions if the principal loses capacity.
- Can be marked irrevocable or revocable.
- Must either be signed by the principal in the presence of a witness, or
- Can be signed by the principal in the presence of a notary.

Financial Power of Attorney:

- Allows the principal to name an agent and a secondary agent to make financial decisions for the principal.
- Can take effect immediately upon signing or after the principal loses capacity, dependent upon how it is written.
- Principal chooses what authority they wish to grant and denotes this with initials by the various sub-sections, which also must be initialed by the witness.
- Must be signed by the principal in the presence of both a witness and a notary.

Living Will:

- Allows the principal to state their end of life preferences in writing.
- Principal choses what they do or do not want by way of life sustaining treatment, if they are in a terminal or irreversible condition.
- Must either be signed by the principal in the presence of a witness, or
- Can be signed by the principal in the presence of a notary.

Key Definitions:

- **Principal:** The person who has legal authority to act, i.e. the person choosing alternate decisions makers.
- **Primary Agent:** The primary or first decision maker for the principal.
- **Secondary Agent:** The alternate or second decision maker, should the primary agent be unavailable.
- **Witness:** An individual over the age of 18, who is not related to the principal, will not be inheriting anything from the principal, is not the principal's caregiver, and is not the principal's agent.
- **Notary:** An individual who is licensed by the State to perform acts in legal affairs, in particular the witnessing of signatures on legal documents, is not related to the principal, will not be inheriting anything from the principal, is not the principal's caregiver, and is not the principal's agent.
- **Irrevocable:** Not able to be changed or reversed.
- **Revocable:** Can be changed.

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HEALTH CARE POWER OF ATTORNEY
Instructions and Information

GENERAL INSTRUCTIONS: Use this form if you want to select a person, called an "agent", to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Be sure you understand the importance of this document. It is a good idea to talk to your doctor and loved ones if you have questions about the type of health care you do or do not want.

AUTOPSY CHOICE: If there is no legal reason to require an autopsy, you can decide if you want one done when you die, or whether you want your agent to choose for you. There is usually a charge for voluntary autopsies. You can help your family and loved ones by making your preferences on this topic clear. For additional information on autopsies please review Arizona Revised Statutes §§ 11-591 and 11-597.

ORGAN DONATION CHOICE (OPTIONAL): You can determine if you want to donate organs or tissues, and if you do, what organs or tissues you want to donate, for what purposes, and to what organizations. You also have the option of whole-body donation for research purposes. You can also choose to have your agent decide. For additional information on Organ Donation, please review Arizona Revised Statutes §§ Title 36, Chapter 7, Article 3 for the laws that pertain to it.

FUNERAL AND BURIAL CHOICE (OPTIONAL): You can determine, your funeral and burial choices in this form. You can select if, upon your death, you would like to be buried and where, or if you would like to be cremated and where your ashes will go, or you can select your agent to make that choice.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:
(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

OFFICE OF THE ARIZONA ATTORNEY GENERAL
MARK BRNOVICH

Health Care Power of Attorney

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Selection of my health care power of attorney and alternate:

I choose the following person to act as my agent to make health care decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

I choose the following person to act as an alternate to make health care decisions for me if my first agent is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

I AUTHORIZE my agent to make health care decisions for me when I cannot make or communicate my own health care decisions. I want my agent to make all such decisions for me except any decisions that I have expressly stated in this form that I do not authorize him/her to make. My agent should explain to me any choices he or she made if I am able to understand. I further authorize my agent to have access to my "personal protected health care information and medical records". This appointment is effective unless it is revoked by me or by a court order.

Health care decisions that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None")

_____

_____

_____

My specific wishes regarding autopsy (additional information on page 1):

*Please note that if not required by law a voluntary autopsy may cost money. Initial your choice.

_____**:** Upon my death I DO NOT consent to a voluntary autopsy.

_____**:** Upon my death I DO consent to a voluntary autopsy.

_____**:** My agent may give or refuse consent for an autopsy.

My specific wishes regarding organ donation (additional information on page 1):

If you do not initial this section your agent may make these decisions for you. Initial your choice.

_____**:** I DO NOT WANT to make an organ or tissue donation, and I DO NOT want this donation authorized on my behalf by my agent or my family.

_____**:** I have already signed a written agreement or donor card regarding donation with the following individual or institution: _____

_____**:** I DO WANT to make an organ or tissue donation when I die. Here are my directions:

1. **What organs/tissues I choose to donate (initial below):**
   a. _____**:** Whole body
   b. _____**:** Any needed parts or organs
   c. _____**:** These parts or organs only:
      i. _____

2. **I am donating organs/tissue for (initial below):**
   a. _____**:** Any legally authorized purpose
   b. _____**:** Transplant or therapeutic purposes only
   c. _____**:** Research only
   d. _____**:** Other: _____

3. **The organization or person I want my organs/tissue to go to are (initial below):**
   a. _____**:** _____
   b. _____**:** Any that my agent chooses

My specific wishes regarding funeral and burial disposition (additional information on page 1):

_____**:** Upon my death, I direct my body to be buried. (Instead of 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 will make all funeral and burial decisions.

Do you have a living will?

If you have a Living Will, **you must attach** the Living Will to this form. A blank Living Will is available on the Attorney General's website www.azag.gov. Initial below.

_____**:** I have SIGNED AND ATTACHED a completed Living Will to this Health Care Power of Attorney.

_____**:** I have NOT SIGNED a Living Will.

Do you have a POLST (Portable Medical Order)?

A **POLST** form is for when you become seriously ill or frail and toward the end of life. A blank POLST is available on the Attorney General's website www.azag.gov. Initial below.

_____**:** I have SIGNED AND ATTACHED a completed POLST to this Health Care Power of Attorney.

_____**:** I have NOT SIGNED a POLST.

Do you have a Prehospital Medical Care Directive – a type of Do Not Resuscitate form (DNR)?

A blank Prehospital Medical Care Directive or DNR is available on the Attorney General's website www.azag.gov. Initial below.

_____**:** I and my doctor or health care provider HAVE SIGNED a Prehospital Medical Care Directive or DNR on Paper with ORANGE background in the event that Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

_____**:** I have NOT SIGNED a Prehospital Medical Care Directive or DNR.

PHYSICIAN AFFIDAVIT (OPTIONAL)

You may wish to ask questions of your physician regarding a particular treatment or about the options in the form. 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/her file.

I, Dr. _____ have reviewed this 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 this day _____.

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

_____
Signature of Physician

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT

_____ **(Initial)** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

Revocability of this Health Care Power of Attorney: I retain the right to revoke all or any portion of this form or to disqualify any agent designated by me in this document.

MY SIGNATURE VERIFICATION FOR THE HEALTH CARE POWER OF ATTORNEY

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document, your witness/notary may sign and initial for you. If applicable have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Health Care Power of Attorney expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS (See Page 1 for who CANNOT be a witness)

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form. I affirm that I meet the requirements to be a witness as indicated on page one of the health care power of attorney form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY (See Page 1 for who CANNOT be a Notary)

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTORIAL JURAT: Pertains to all five pages of this Health Care Power of Attorney Dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principal's Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____

OFFICE OF THE ARIZONA ATTORNEY GENERAL
MARK BRNOVICH

Mental Health Care Power of Attorney

GENERAL INSTRUCTIONS: Use this form if you want to appoint a person, also referred to as your "agent", to make future mental health care decisions for you if you become incapable of making those decisions for yourself.

The decision about whether you are incapable can only be made by a specialist in neurology or an Arizona licensed psychiatrist or psychologist who will evaluate whether you can give informed consent. Be sure you understand the importance of this document. It is a good idea to talk to your doctor and loved ones if you have questions about the type of mental health care you do or do not want.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it. **PLEASE NOTE:** At least one adult witness OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:
(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Selection of my mental health care power of attorney and alternate:

I choose the following person to act as my agent to make mental health care decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

I choose the following person to act as an alternate to make mental health care decisions for me if my first agent is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my agent to make for me if I become incapable of making my own mental health care decisions due to mental or physical illness, injury, disability, or incapacity. This appointment is effective unless and until it is revoked by me or by an order of a court. My agent is authorized to do the following which I have initialed or marked:

_____**:** To receive medical records and information regarding my mental health treatment and to receive, review, and consent to disclosure of any of my medical records related to that treatment.

_____**:** To consent to the administration of any medications recommended by my treating physician.

_____**:** To admit me to an inpatient or partial psychiatric hospitalization program.

_____**:** Other: _____

_____

_____

Mental health care treatments that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None")

_____

_____

Revocability of this Mental Health Care Power of Attorney: This mental health care power of attorney or any portion of it may not be revoked and any designated agent may not be disqualified by me during times that I am found to be unable to give informed consent. However, at all other times I retain the right to revoke all or any portion of this mental health care power of attorney or to disqualify any agent designated by me in this document.

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT

_____ **(Initial)** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release of authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

MY SIGNATURE VERIFICATION FOR THE MENTAL HEALTH CARE POWER OF ATTORNEY

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Health Care Power of Attorney expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS (See Page 1 for who CANNOT be a witness)

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form. I affirm that I meet the requirements to be a witness as indicated on page one of the mental health care power of attorney form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY (See Page 1 for who CANNOT be a Notary)

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTORIAL JURAT: Pertains to all three pages of this State of Arizona Mental Health Care Power of Attorney dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principal's Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____

FINANCIAL DURABLE GENERAL POWER OF ATTORNEY

Advisory Notice to Agent: ARS § 14-5506 governs the exercise of powers of attorney. Under that statute, an agent cannot receive ANY benefits from the principal unless those benefits are specifically identified in detail within this instrument or within a written contract. Otherwise, the agent could be subject to criminal prosecution or subject to the penalty provisions of ARS § 46-456, which authorizes the loss of the agent's right to inherit from the principal as well as payment of treble damages and attorneys' fees. An agent should carefully review these statutes or consult with a knowledgeable attorney prior to exercising the authority granted by this power of attorney.

ARTICLE ONE
GRANT OF POWERS

I, the undersigned principal, _____ currently residing at _____, hereby appoint _____, currently residing at _____, (hereinafter referred to as the "Agent"), as my attorney in fact, hereby granting the Agent full power and authority, as though the Agent were the absolute owner of my assets and liabilities, to perform those acts for me and in my name, place, and stead as expressly provided below as fully as I could perform if personally present and not disabled, incapacitated or incompetent.

THIS POWER OF ATTORNEY SHALL BECOME EFFECTIVE AS OF THE DATE I SIGN THIS DOCUMENT AND SHALL NOT BE AFFECTED BY MY DISABILITY, INCAPACITY OR INCOMPETENCY OR BY LAPSE OF TIME.

By placing my initials following the description of each selected power set forth below, and by causing the witness to place his or her initials below my initials for each selected power, the principal acknowledges that [s/he] has reviewed and expressly approved of the delegation hereunder of each selected power to my Agent):

1. Power to Buy and Sell. To transfer, sell, purchase, lease, encumber, assign, exchange and convey, or exercise any option, election, privilege or power with respect to any or all property, real and personal, tangible and intangible, within or without the State of Arizona, as the Agent in his or her sole discretion determines, and to disclaim any interest in any property to which I would otherwise succeed.

Initials: _____ _____
Principal Witness

2. Power with Respect to Bank Accounts. To establish accounts of all kinds, including, without limitation, checking and savings accounts, for me with financial institutions of any kind, including banks and other similar financial institutions; to modify, terminate, make deposits to or write checks on or make withdrawals from and grant security interests in all accounts in my name or with respect to which I am an authorized signatory (except any accounts held by me in a fiduciary capacity), whether or not such account was established by me or for me by the Agent, to negotiate, endorse or transfer any checks or other instruments with respect to any such accounts; and to contract for any services rendered by any

bank or financial institution.

Initials: _____ _____
Principal Witness

3. Power with Respect to Safe Deposit Boxes. To contract with any institution for the maintenance of a safe deposit box in my name; to have access to all safe deposit boxes in my name or with respect to which I am an authorized signatory, whether or not the contract for such safe deposit box was executed by me (either alone or jointly with others) or by the Agent in my name; to add to and remove from the contents of any such safe deposit box and to terminate any and all contracts for such boxes.

Initials: _____ _____
Principal Witness

4. Power to Demand, Receive, Prosecute or Defend. To ask, demand, sue for and receive all sums of money which are or shall become due, owing or payable to me, or which belong or shall belong to me, whether social security benefits, pension payments, individual retirement accounts, dividends, interests, annuities, debts, or any other receivables, and to use all lawful ways and means in my name for the recovery thereof, and to prosecute or defend actions, claims or proceedings in any jurisdiction. and to defend suits at law.

Initials: _____ _____
Principal Witness

5. Brokerage Accounts. With respect to any account with any brokerage firm: (a) to effect purchases and sales (including short sales), to subscribe for and to trade in stocks, bonds, options, or other securities, or limited partnership interests or investments and trust units, whether or not in negotiable form, issued or unissued, foreign exchange, commodities, and contracts relating to same (including commodity futures), on margin or otherwise, for my account(s) and risk; (b) to deliver to any third party securities for my account(s), and to instruct any third party to deliver securities from my account(s) to any other brokerage firm or to others, and in such name and form as the Agent may direct; (c) to instruct any third party to make payment of moneys from my account(s) with any third party, and to receive and direct payments there from payable to me or to others; (d) to sell, assign, endorse and transfer any stocks, bonds, options or other securities of any nature, at any time standing in my name and to execute any documents necessary to effectuate the foregoing; (e) to receive statements of transactions made for my account(s); (f) to approve and confirm the same, to receive any and all notices, calls for margin, or other demands with reference to my account(s); and (g) to make any and all agreements with any third party with reference thereto for me and on my behalf.

Initials: _____ _____
Principal Witness

6. Employ Consultants. To employ, compensate and terminate the services of financial, investment and legal advisors and consultants.

Initials: _____ _____
Principal Witness

7. Power with Respect to Insurance. To purchase, maintain, surrender, collect or cancel (a) life insurance or annuities of any kind on my life or the life of any one in whom I have an insurable interest, (b) liability insurance protecting me and my estate against third party claims, (c) hospital insurance, medical insurance, Medicare supplement insurance, custodial care insurance, and disability income insurance for me or any of my dependents, and (d) casualty insurance insuring assets of mine against loss or damage due to fire, theft, or other commonly insured risk; to pay all insurance premiums, to select any options under such policies, to increase coverage under any such policy, to borrow against any such policy, to pursue all insurance claims on my behalf, to adjust insurance losses; and the foregoing powers shall apply to private and public plans, including, without limitation, Medicare, Medicaid, and Workers' Compensation.

Initials: _____ _____
Principal Witness

8. Power to Provide for Principal's Support. To do all acts necessary for maintaining my customary standard of living, to provide living quarters by purchase, lease or other arrangement, or by payment of the operating costs of my existing living quarters, including interest, amortization payments, repairs and taxes, to provide normal domestic help for the operation of my household, to provide clothing, transportation, medicine, food and incidentals, and if necessary to make all necessary arrangements, contractual or otherwise, for me at any hospital, hospice, nursing home, convalescent home or similar establishment, or in my own residence should I desire it, and to assure that all of my essential needs are provided for at such a facility or in my own residence, as the case may be.

Initials: _____ _____
Principal Witness

9. Income Tax Returns. To prepare and file any federal, state or local income tax return on my behalf and to deal with any governmental agency with respect to any of my tax returns.

Initials: _____ _____
Principal Witness

10. Nomination of Guardian/Conservator. While I hope that by executing this instrument I will have obviated the need for a guardianship and conservatorship of my person and of my estate, if it should become necessary for a guardian or conservator to be appointed for my person or for my estate, I nominate the Agent to so serve.

11. Alternate Agents. If the Agent designated in the introductory paragraph of Article One above cannot serve or continue to serve or is unavailable to serve, I appoint _____, to serve as my Alternate Agent ("Alternate Agent"). No Alternate Agent shall be liable for any act or omission of the initial Agent.

12. Benefit to Agent. My agent shall be entitled to reasonable compensation for any services provided as my Agent, which compensation shall be up to $_____ per hour. My agent shall be entitled to reimbursement of all reasonable expenses incurred as a result of carrying out any provision of

this Power of Attorney.

Initials: _____ _____
Principal Witness

13. General Power of Appointment. Nothing in this instrument shall be construed as creating in the Agent a general power of appointment exercisable in its own behalf, or for the benefit of the Agent's estate, the Agent's creditors, or creditors of the estate of the Agent.

14. Limitations on Authority. The Agent shall not have any power to amend, alter, or revoke any will or codicil.

15. Revocation of Prior Powers of Attorney. I hereby revoke all powers of attorney, whether general or limited, previously granted by me as principal and terminate all agency relationships created thereunder, including, without limitation, those relationships of all successor agents named therein, if any, except any powers granted by me on forms provided by financial institutions granting the right to write checks or deposit funds to or withdraw funds from accounts to which I am a signatory or granting access to a safe deposit box shall not be hereby revoked, but shall continue to be in full force and effect.

16. Ratification. I hereby ratify and approve any act or failure to act of the Agent in good faith and any such act done by the Agent at any time, including but not limited to, any act done at any time at which I am disabled, incompetent or incapacitated or at any time at which there is uncertainty as to whether I am dead or alive, shall, unless otherwise invalid or unenforceable, have the same effect and bind me, my guardian, heirs, distributees, legatees, devisees, assignees, and personal representatives to the same extent as if I had been alive and not disabled, incapacitated, or incompetent at the time of such act.

17. Protection for Third Parties. Any person or entity acting without negligence and in good faith in reasonable reliance on this power of attorney shall not incur any liability thereby, nor shall the fact that time has elapsed since its execution prevent such persons or entity from reasonably relying on this instrument. Persons and entities shall place reasonable reliance on this power of attorney regardless of whether it has been filed for record and may request the issuance of an affidavit by the Agent on which the third party may rely.

18. Governing Law. The laws of the State of Arizona shall govern this power of attorney in all respects.

I, _____, the principal, sign my name to this Financial Durable General Power of Attorney this ___ day of _____, 20__, and being first duly sworn, do declare to the undersigned authority that I sign and execute this instrument as my Power of Attorney and that I sign it willingly, or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in the Financial Durable General Power of Attorney and I declare that I am eighteen

years of age or older, of sound mind and under no constraint or undue influence.

_____

Principal

WITNESS: I, **_____,** the witness, sign my name to the foregoing Financial Durable General Power of Attorney being first duly sworn and I do declare to the undersigned authority that the principal has signed and executed this instrument as his/ her power of attorney and that he/she signed it willingly, and that I, in the presence and hearing of the principal, signed this power of attorney as a witness to the principal's signing and that to the best of my knowledge the principal is eighteen years of age or older, of sound mind and under no constraint or undue influence.

Dated: _____ _____

Signature of Witness

_____

Printed Name of Witness

STATE OF ARIZONA)
) ss.
County of _____)

Subscribed, sworn to, and acknowledged before me, the undersigned Notary Public, by _____, the principal, and subscribed, sworn to, and acknowledged before me by _____, witness, this ____ day of _____, 20__.

_____

Notary Public

LIVING WILL (End of Life Care)
Instructions

GENERAL INSTRUCTIONS: Use this form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean.

The Living Will is your written directions to your health care power of attorney, also referred to as your "agent", your family, your physician, and any other person who might make medical care decisions for you if you are unable to communicate yourself.

It is a good idea to talk to your doctor and loved ones if you have questions about the type of care you do or do not want.

IMPORTANT: If you have a Living Will and a Health Care Power of Attorney, you must attach the Living Will to the Health Care Power of Attorney.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:
(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

OFFICE OF THE ARIZONA ATTORNEY GENERAL
MARK BRNOVICH

Living Will

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Some general statements about your health care choices are listed below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully BEFORE you initial your preferred statement. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3 and 4, BUT if you initial paragraph 5 the others should not be initialed.

_____ 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, that would serve only to artificially delay the moment of my death.

***Comfort care is treatment given in an attempt to protect and enhance the quality of life without artificially prolonging life.*

_____ 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:

_____ a. Cardiopulmonary resuscitation (CPR). For example: the use of drugs, electric shock and artificial breathing.

_____ b. Artificially administered food and fluids.

_____ c. To be taken to a hospital if at all avoidable.

_____ 3. Regardless of any other directions I have given in this Living Will, 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.

_____ 4. Regardless of any other directions I have given in this Living Will, 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. I want my life to be prolonged to the greatest extent possible (If you initial here, you should not initial any of the others).

PLEASE NOTE: You can attach additional instructions on your medical care wishes that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

_____ A. I HAVE NOT attached additional special instructions about End of Life Care I want.

_____ B. I HAVE attached additional special provisions or limitations about End of Life Care I want.

MY SIGNATURE VERIFICATION FOR THE LIVING WILL

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Living Will expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTORIAL JURAT: Pertains to all three pages of this Living Will

Dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principals Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____