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How to Complete Your California Advance Health Care Directive

Statutory Form (California Probate Code Section 4701, as amended effective January 1, 2024)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR ADVANCE HEALTH CARE DIRECTIVE.

About this form. This is California's official statutory form for naming a health care agent and writing down your wishes for your **physical and mental health care**. It does **not** cover finances — for that, use a California Uniform Statutory Form Power of Attorney. It is also not a POLST or DNR order, which you complete with your doctor. You may fill out all of this form or only the parts you want. **You can type into this form on your computer and then print it — but sign and date only in front of your witnesses or notary.**

1. **Name your agent (Part 1)**
   Enter the name, address, and phone numbers of the person who will make health care decisions for you, and up to two alternates (optional). Your agent may not be your supervising health care provider, or an operator or employee of the facility where you are receiving care, unless that person is related to you or is a coworker.
2. **Decide when it starts (Section 1.3)**
   Your agent's authority begins when your primary physician determines you cannot make your own decisions. Mark the box in 1.3 only if you want it to take effect immediately.
3. **Your health care wishes (Part 2 — optional)**
   Mark one end-of-life choice in 2.1, note any limits on pain relief in 2.2, and add other instructions in 2.3. You may strike any wording you do not want, or skip Part 2 and let your agent decide.
4. **Organ donation and primary physician (Parts 3–4 — optional)**
   Mark the box in 3.1 to donate and strike any purposes you do not want. In Part 4 you may name a primary physician.
5. **Sign in front of a notary (Part 5 / last page)**
   A notary verifies your identity and completes the acknowledgment on the last page — no need to find two witnesses who meet the legal rules. Bring a current government-issued photo ID and do **not** sign ahead of time. Witnesses, if used instead, must meet the requirements printed in Sections 5.3 and 5.4.
6. **Skilled nursing facility patients (Part 6)**
   If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must also sign as a witness — this is required even if the form is notarized.

After It's Signed

- Give copies to your agent, your doctor, other health care providers, and any facility where you receive care. A copy has the same effect as the original. Keep the original where it is easy to find (not a safe deposit box).
- You can revoke or replace it at any time. Revoking your agent's appointment requires a signed writing or personally telling your supervising health care provider. Tell everyone who has a copy.
- Optional: register it with the California Secretary of State's Advance Health Care Directive Registry, and carry the wallet card included at the end of this packet.

Need a Notary and Witnesses? We Come to You.

Homes • Hospitals • Care Facilities • Offices • Available Anytime
Qualified witnesses available for an additional fee.

California-Commissioned Notaries

SCAN TO BOOK

Questions about this document? Talk to an attorney. Gavrilov & Brooks Law Firm has attorneys licensed in California, Nevada, and other states. Phone and video consultations are available. **(916) 504-0529** · **www.gavrilovlaw.com**

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ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own physical and mental health care. You also have the right to name someone else to make those health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) For all physical and mental health care, approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Donate your organs, tissues, and parts, authorize an autopsy, and direct disposition of remains.

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization, or abortion for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs, tissues, and parts following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form shall be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that they understand your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

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PART 1 POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____
(name of individual you choose as agent)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____ _____
(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____
(name of individual you choose as first alternate agent)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____ _____
(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____
(name of individual you choose as second alternate agent)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____ _____
(home phone) (work phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all physical and mental health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

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(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

☐ If I mark this box, my agent's authority to make health care decisions for me takes effect immediately.

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

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PART 2 INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ **(a) Choice Not To Prolong Life**
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, **OR**

☐ **(b) Choice To Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(Add additional sheets if needed.)

(2.3) WISHES FOR PHYSICAL AND MENTAL HEALTH CARE: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

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PART 3 DONATION OF ORGANS, TISSUES, AND PARTS AT DEATH (OPTIONAL)

☐ **(3.1)** Upon my death, I give my organs, tissues, and parts (mark box to indicate yes). By checking the box above, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

My donation is for the following purposes (strike any of the following you do not want):

(a) Transplant (b) Therapy (c) Research (d) Education

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines:

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or in Section 1.5 of this form).

PART 4 PRIMARY PHYSICIAN (OPTIONAL)

(4.1) I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____
(phone)

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PART 5 SIGNATURE AND WITNESSES

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

(date) (sign your name)

(address) (print your name)

(city) (state)

Sign in the presence of a notary public (Certificate of Acknowledgment on the last page) or two qualified witnesses (Sections 5.3 and 5.4).

(5.3) STATEMENT OF WITNESSES: 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, (2) that the individual signed or acknowledged this advance 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 directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness

(print name)

(address)

(city) (state)

(signature of witness)

(date)

Second witness

(print name)

(address)

(city) (state)

(signature of witness)

(date)

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(5.4) ADDITIONAL STATEMENT OF WITNESSES: 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 their death under a will now existing or by operation of law.

(signature of witness)

(signature of witness)

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PART 6 SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF 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.

_____ _____

(date) (sign your name)

_____ _____

(address) (print your name)

_____ _____

(city) (state)

This statement is required whether this directive is signed before two witnesses or acknowledged before a notary public (Probate Code Section 4675).

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CERTIFICATE OF ACKNOWLEDGMENT

Notary acknowledgment of the principal's signature on this Advance Health Care Directive.

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 _____ before me, _____

(here insert name and title of the officer)

personally appeared _____

, who 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 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.

(Seal)

Signature _____

WALLET CARDS

Keep this page — it is not part of your Advance Health Care Directive.

ATTN: CALIFORNIA HEALTH CARE PROVIDERS

I have a California Advance Health Care Directive:

- ☐ Power of Attorney for Health Care (agent named)
- ☐ Instructions for Health Care
- ☐ Registered with CA Secretary of State

Please contact _____

Phone _____

My name _____

Signature _____ Date _____

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- ☐ Registered with CA Secretary of State

Please contact _____

Phone _____

My name _____

Signature _____ Date _____

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- ☐ Instructions for Health Care
- ☐ Registered with CA Secretary of State

Please contact _____

Phone _____

My name _____

Signature _____ Date _____

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- ☐ Power of Attorney for Health Care (agent named)
- ☐ Instructions for Health Care
- ☐ Registered with CA Secretary of State

Please contact _____

Phone _____

My name _____

Signature _____ Date _____

Complete and cut out the cards above. Keep one in your wallet with your driver's license or health insurance card, and keep the others in easy-to-find places such as your car's glove compartment or on your refrigerator.