#L-704 10/18/83

First Supplement to Memorandum 83-99

Subject: Study L-704 - Durable Power of Attorney for Health Care (Statutory Form)

We have received a letter from Charles F. Forbes of the law firm of Musick, Peeler & Garrett (copy attached as Exhibit 1). The letter contains comments on the draft of the statutory form for durable power of attorney for health care that was prepared for the last meeting. You will recall that this form was substantially revised at the last meeting. The revised form (incorporating the decisions made at the last meeting) is attached to Memorandum 83-99.

The staff has reviewed the revised form attached to Memorandum 83-99 in light of the suggestions made by Mr. Forbes. We suggest that a number of revisions be made in that revised form. We have marked our suggested revisions on the copy of the revised form attached as Exhibit 2 to this memorandum.

We do not include the revision suggested for the statement of desires as to prolonging of life. See pages 4-5 of the Forbes redrafted form attached to Exhibit 1. The suggested revision is a great improvement on the first staff draft, but the staff recommends against including this in the proposed legislation. Including this material in the enclosed legislation would result in considerable controversy, especially if we are to give meaning to what "life sustaining or prolonging treatment" is.

The letter suggests that space be provided for only two witnesses. We have provided space for three. Does the Commission wish to eliminate the space for one of the three and to revise the instructions to indicate that only two witnesses should be used?

The letter suggests (page 8 of the Forbes redrafted form attached to Exhibit 1) that the form be revised to include special provisions relating to certain special requirements. The staff would prefer to omit this material from the form and to merely provide a space to check whether a special requirement applies.

The letter suggests that the following statement concerning copies be included at the end of the statutory form:

COPIES

> Upon completion, you should give a signed copy of this form to your designated agent, and to your alternative agents. You should also retain a copy for yourself so that it can be made available to your health care provider.

This provision raises a question as to what suggestion should be made to the principal concerning the custody of the completed form. A "signed copy" is not itself sufficient. The document must be notarized or witnessed as well. We probably would not want many duplicate originals to be executed. That would create a problem if the principal wanted to revoke the document. It would be easier to revoke if the principal retained the original document. In addition, if the copy is only "signed," how do we know it was witnessed? A provision could be added to the statute to permit the health care provider to rely on a photocopy of the original. What instruction (if any) does the Commission believe should be included in the recommended legislation?

Respectfully submitted,

John H. DeMoully
Executive Secretary

1st Supp Memo 83-99 Exhibit 1

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WRITER'S DIRECT DIAL NUMBER

October 10, 1983

John H. DeMoully
Executive Secretary
California Law Revision Commission
400 Middlefield Road, Room D-2
Palo Alto, California 94306

Dear Mr. DeMoully:

We appreciate your giving us an opportunity to comment on the statutory short form durable power of attorney for health care you have drafted. Although we were not able to respond prior to the commission's September 22-24 meeting, we trust our comments will be helpful as your work progresses. We have not reviewed the statutory short durable power of attorney for property matters, consequently we will address only the proposed form for health care decisions.

In general we endorse the concept of statutory short forms, and the development of such a form for designating an attorney-in-fact to make health care decisions is particularly appropriate since it will allow a person who may not have access to legal counsel to appoint an attorney-in-fact. However, this purpose may be achieved only if the forms are easily understood and it may be appropriate to modify several provisions in the form in order to simplify it.

We agree with your statement that the most important aspect of the form is the section in which a person may indicate his desires regarding life-sustaining treatment. We recognize the difficulty in drafting appropriate statements and have suggested alternative provisions which hopefully will not unduly restrict a person's options, which we fear could occur if the proposed statements are used.

I. General Recommendations

The proposed statutory short form is generally excellent although it could be simplified in some respects. We have

enclosed a revised form which includes the following recommended changes. Several sections in the proposed form refer the reader to applicable code sections which increases the reader's difficulty in completing the form. Whenever possible, it is helpful to summarize relevant statutory requirements and definitions rather than requiring a reading of the code sections for clarity. In the enclosed form we have summarized the applicable statutory provisions. Specifically, we recommend deleting sections 10, 11 and 12 of the warning and instead fully defining the applicable sections throughout the form. Additionally, throughout the enclosed form we have used only the term "Agent" rather than using the terms "Agent" and "Attorney-in-Fact" interchangeably. We recommend using the term you prefer consistently throughout the entire form.

A. Special Provisions

We believe it is helpful to place the section where a person may indicate "special provisions and limitations" on the Agent's authority after the section establishing the attorney-in-fact's "general authority", in order to clarify that this section is to be used to indicate special limitations on the attorney-in-fact's general authority. The present placement of this section after the "statement of desires" suggests that this section should contain further elaboration of the patient's desires regarding withholding and withdrawal of life support.

We also revised the "special provisions" instructions since the proposed language suggested that a person could indicate types of treatment or placements which he or she did not want to be "used" as distinguished from expressing limitations on the attorney-in-fact's authority to make these decisions. The examples of other treatments used in this section, e.g., placement in a mental health facility, or convulsive therapy, are not therapies that simply may not be used, but instead are particular treatments that may be authorized only in accordance with special statutory procedures.

B. Agent Designation

We have changed the explanation regarding the categories of person who cannot be named as agent to indicate: "(1) Your treating health care providers and (2) An employee of your treating health care provider," in order to clarify that the only

medical professionals who may not be a person's agent are those providing medical treatment for the principal.

II. Definition of General Authority

The proposed section 2510 provides a detailed explanations of the powers provided to an agent. In our opinion it may not be useful or necessary to specifically define the particular authority that may be granted since Senate Bill 762's general explanation of an attorney-in-fact's authority covers these categories. To some extent, new definitions might create confusion regarding whether a power of attorney which is executed pursuant to the statutory short form grants a different general authority than one executed pursuant to Senate Bill 762.

In light of our preference for a general, rather than specific statement of an attorneys-in-fact's authority, the revised form explains that, unless specific limitations are noted, the attorney-in-fact has "full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an physical or mental condition, subject to any limitations in this document."

III. Statement of Desires

Your statutory form provides two choices in regard to life-prolonging procedures. The first choice is "prolong my life to the greatest extent possible," and the second is "refuse life-prolonging procedures, if the attorney-in-fact believes that I myself would do so. . ." We feel this proposed section and accompanying legislation perhaps unduly limits a person to making an all or nothing choice in regard to life-prolonging therapy.

Additionally, the proposed statement, which would authorize withholding a withdrawal of treatment, is somewhat circular as it requires the attorney-in-fact to refuse treatment if he believes the patient would do so. This assumes the agent "knows" what the principal's desires are regarding when to refuse life-prolonging treatment. We suggest modifying these statements to provide a greater opportunity for the principal to set forth

the circumstances in which he would request or refuse life-prolonging procedures.

The suggestion in your letter that the form allow a person to express his desire to "Refuse life-prolonging procedures if the Attorney-in-Fact believes that it is unlikely that I will ever recover substantially normal physical abilities or mental capacities" is a step in the direction of defining these desires for the agent. However, it may generate opposition on the grounds that it improperly gives the attorney-in-fact authority to decide when a person has become "worthless", by virtue of mental incapacity, and therefore should not continue to receive treatment. Instead, we believe the inquiry should focus on the patient's medical condition, and whether he is suffering from an irreversible coma, or incurable, or terminal condition.

Also, the proposed legislation, which would specify particular modes of treatment that may be withheld or withdrawn, would be very helpful if it were enacted in the proposed form. However, we expect that such legislation is likely to be amended drastically to limit the types of treatment and procedures that may be discontinued, in a manner which would inappropriately restrict proper decision making. This opinion is based upon our experience with the limiting legislative amendments to the Natural Death Act and the controversy created by Senate Bill 762. As we have concluded that your proposed legislation may create, rather than resolve problems, we urge you to reconsider proposing legislation which sets forth lists of treatment that may be withheld or withdrawn, and recommend instead utilizing the more general language of the Senate Bill.

We hope our comments will be helpful to you. Please contact us if you have any questions regarding our comments or if we can be of further assistance to you.

Very truly yours,

Charles F. Forbes
for MUSICK, PEELER & GARRETT

cc: Keith Walley

STATUTORY SHORT FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(California Civil Code Sections 2500-2512)

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT (THE ATTORNEY-IN-FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE CONSENT, REFUSAL OF CONSENT, OR WITHDRAWAL OF CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

2. YOUR AGENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF YOUR AGENT MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

4. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR

DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

5. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST FOR SEVEN YEARS FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AT THE TIME WHEN THIS SEVEN-YEAR PERIOD ENDS, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

6. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT BY:

A. NOTIFYING THE AGENT OF THE REVOCATION ORALLY OR IN WRITING.

B. NOTIFYING THE TREATING PHYSICIAN, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING.

7. YOUR AGENT HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

8. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

9. <u>IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU</u>.

1. DESIGNATION OF HEALTH CARE AGENT. I,_____

(insert your name)

do hereby designate and appoint: Name:_____

Address:_____

Telephone Number:_____

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your agent to make health care decisions for you. None of the following may be designated as agent: (1) your treating health care provider, (2) an employee of your treating health care provider, (3) an operator of a community care facility, or (4) an employee of an operator of a community care facility.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me as allowed by Sections 2500 to 2512, inclusive, of the California Civil Code. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the Agent named above full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, subject only to the limitations and special provisions, if any, set forth in Paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS.

(By law, your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your agent to have authority to give consent for or other restriction you wish to place on your agent's authority, you should list them in the space below. If you do not write in any limitations, your agent will have the broad powers to make health care decisions on your behalf which are set forth in Paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, the authority of my Agent is subject to the following special provisions and limitations:

_____

_____

_____

_____

5. DURATION. I understand that this power of attorney will exist for seven years from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my Agent will continue to exist until the time when I become able to make health care decisions for myself.

I wish to have this power of attorney end before seven years on the following date: _____.

6. STATEMENT OF DESIRES.

(With respect to decisions to withhold or withdraw life-sustaining treatment, your Agent must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, the Agent has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

(If the statement reflects your desires, initial the box next to the statement.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long term survival, or the cost of the procedures. [_____]

2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments or procedures <u>not</u> be used. [_____]

3. If I have an incurable or terminal condition or illness and no reasonable hope of long term recovery or survival, I desire that life sustaining or prolonging treatments not be used. [_____]

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires: _____

_____

_____

_____

_____

7. DESIGNATION OF ALTERNATE AGENTS.

(You are not required to designate any alternative agents but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the Agent designated in Paragraph 1 above in the event that Agent is unable or unwilling to act as your Agent. Also, if the Agent designated in Paragraph 1 is your spouse, his or her designation as your Agent is automatically revoked by law if your marriage is dissolved.)

If the person designated as my Agent is unable to make health care decisions for me, then I designate the following persons to serve as my Agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Agent

Name: _____

Address: _____

Telephone Number: _____

B. Second Alternative Agent

Name: _____

Address: _____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Short Form Durable Power of Attorney for Health Care on _____ at
(Date)

_____, _____.
(City) (State)

_____
(Signature)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS EITHER (1) ACKNOWLEDGED BEFORE A NOTARY PUBLIC IN CALIFORNIA OR (2) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO PERSONALLY KNOW YOU AND ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE.)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of California)
) ss.
County of _____)

On this _____ day of _____, in the year _____, before me, _____,
(here insert name of notary public)

personally appeared _____
(here insert name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

_____
(Signature of Notary Public)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of community care facility, (5) an employer of an operator of a community care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury under the laws of California that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Signature:_____ Residence Address:_____

Print Name:_____ _____

Date:_____ _____

Signature:_____ Residence Address:_____

Print Name:_____ _____

Date:_____ _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury under the laws of California that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Signature: _____

SPECIAL REQUIREMENTS

(Special additional requirements must be satisfied for this document to be valid if (1) you are a patient in a skilled nursing facility or (2) you are a conservatee under the Lanterman-Petris-Short Act and you are appointing the conservator as your agent to make health care decisions for you.)

1. If you are a patient in a skilled nursing facility (as defined in Health and Safety Code Section 1250(c)) at least one witness must be a patient advocate or ombudsman. The patient advocate or ombudsman must sign the witness statement and must also sign the following declaration.

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 am serving as a witness as required by subdivision (a)(2)A of Civil Code 2432.

Signature:_____ Address:_____

Print Name:_____ _____

Date:_____ _____

2. If you are a conservatee under the Lanterman-Petris-Short Act (of Division 5 of the Welfare and Institutions Code) and you wish to designate your conservator as your agent to make health care decisions, you must be represented by legal counsel. Your lawyer must sign the following statement:

I have advised my client _____ concerning
Name
his or her rights in connection with this matter and the consequences of signing or not signing this durable power of attorney and my client, after being so advised, has executed this durable power of attorney.

Name:_____ Address:_____

Print Name:_____ _____

Date:_____ _____

COPIES

Upon completion, you should give a signed copy of this form to your designated agent, and to your alternative agents. You should also retain a copy for yourself so that it can be made available to your health care provider.

SEC. __. Chapter 4 (commencing with Section 2500) is added to Title 9 of Part 4 of Division 3 of the Civil Code, to read:

CHAPTER 4. STATUTORY SHORT FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE

§ 2500. Statutory short form of durable power of attorney for health care

2500. The use of the following form in the creation of a durable power of attorney for health care under Article 5 (commencing with Section 2430) of Chapter 2 is lawful, and when used, the power of attorney shall be construed in accordance with the provisions of this chapter and shall be subject to the provisions of Article 5 (commencing with Section 2430) of Chapter 2:

STATUTORY SHORT FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(California Civil Code Section 2500)

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. 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 CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE KNOWN. IF YOUR DESIRES ARE UNKNOWN, YOUR AGENT MUST MAKE DECISIONS THAT IN THE JUDGMENT OF THE AGENT ARE IN YOUR BEST INTERESTS.

2. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR DOCTOR WITHHOLDING OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE.

3. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, 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.

4. 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 OR PLACEMENTS THAT YOU DO NOT DESIRE.

5. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST FOR SEVEN YEARS FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AT THE TIME WHEN THIS SEVEN-YEAR PERIOD ENDS, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

6. YOU HAVE THE RIGHT TO REVOKE THE ~~APPOINTMENT~~ AUTHORITY OF YOUR AGENT BY NOTIFYING THE AGENT ~~OF THE REVOCATION ORALLY OR IN WRITING~~.

~~7. YOU HAVE THE RIGHT TO REVOKE YOUR AGENT'S AUTHORITY TO MAKE~~ HEALTH CARE DECISIONS ~~FOR YOU BY NOTIFYING THE~~ OR YOUR TREATING PHYSICIAN, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING. OF THE REVOCATION

~~7.~~ 8. YOUR AGENT HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

~~8.~~ 9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

~~10. YOU SHOULD CAREFULLY READ AND FOLLOW THE WITNESSING PROCEDURE DESCRIBED AT THE END OF THIS FORM. THIS DOCUMENT WILL NOT BE VALID UNLESS YOU COMPLY WITH THE WITNESSING PROCEDURE.~~

11. ~~SPECIAL ADDITIONAL REQUIREMENTS MUST BE SATISFIED FOR THIS DOCUMENT TO BE VALID IF (1) YOU ARE A PATIENT IN A SKILLED NURSING FACILITY AS DEFINED IN HEALTH AND SAFETY CODE SECTION 1250(c) OR (2) YOU ARE A CONSERVATEE UNDER THE LANTERMAN-PETRIS-SHORT ACT AND YOU ARE APPOINTING THE CONSERVATOR AS YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.~~

9 ~~12~~. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

1. DESIGNATION OF HEALTH CARE AGENT. I, _____

_____

(insert your name and address)

do hereby designate and appoint _____

_____

(Insert name and address of one individual only as your agent to make health care decisions for you. None of the following may be designated as agent: (1) a treating health care provider, (2) an employee of a treating health care provider, (3) an operator of a community care facility, or (4) an employee of an operator of a community care facility.)

Name: _____

Address: _____

_____

Telephone Number: ( )

your

your

as my attorney-in-fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care under ~~Article 5 (commencing with Section 2430) of Chapter 2 of Title 9 of Part 4 of Division 3~~ Sections 2430 to 2443, inclusive, of the California Civil Code. This power of attorney shall be construed in accordance with the provisions of Sections 2500 to 2505, inclusive, of the California Civil Code. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to ~~the attorney-in-fact~~ my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, ~~the attorney-in-fact~~ my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to ~~the attorney-in-fact~~ my agent, including but not limited to my desires concerning obtaining or refusing or withdrawing life-prolonging treatment, services, and procedures. If my desires are unknown or unclear, ~~the attorney-in-fact~~ my agent shall make health decisions for me that in the judgment of ~~the attorney-in-fact~~ my agent, are in my best interests.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 9 ("SPECIAL PROVISIONS AND LIMITATIONS") below. You can indicate your desires by including a statement of your desires in paragraph 4 ("STATEMENT OF DESIRES") below.)

4. STATEMENT OF DESIRES. In exercising the authority under this durable power of attorney for health care, ~~the attorney-in-fact~~ my agent shall act consistent with my desires as stated below:

_____

_____

_____

_____

_____

_____

(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires by writing a statement of your desires in the space provided above. You may attach additional pages if you need more space to complete your statement. You can also make your desires known to your agent by discussing your desires with your agent or by some other means.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, the attorney-in-fact has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including but not limited to medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 9 ("SPECIAL PROVISIONS AND LIMITATIONS") below.)

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions the attorney-in-fact is authorized by this document to make, the attorney-in-fact has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

7. UNIFORM ANATOMICAL GIFT ACT. Subject to any limitations in this document, the attorney-in-fact has the power and authority to make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act (Chapter 3.5 Part 1 of Division 7 of the Health and Safety Code).

(If you want to limit the authority of your agent to make a disposition under the Uniform Anatomical Gift Act, you must state the limitations in paragraph 9 ("SPECIAL PROVISIONS AND LIMITATIONS") below.)

8. DURATION.

(Unless you specify a shorter period in the space below, this power of attorney will exist for seven years from the date you execute this document and, if you are unable to make health care decisions for yourself at the time when this seven-year period ends, the power will continue to exist until the time when you become able to make health care decisions for yourself.)

This durable power of attorney for health care expires on _____.

(Fill in this space ONLY if you want the authority of your agent to end EARLIER than the seven-year period described above.)

limitations or restrictions you wish to place on your agent's authority,

9. SPECIAL PROVISIONS AND LIMITATIONS.

(By law, your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other ~~types of treatment or placement that you do not want to be used~~, you should list them in the space below. If you do not write in any limitations, your agent will have broad powers to make health care decisions on your behalf, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, the ~~attorney-in-fact~~ authority of my agent is subject to the following special provisions and limitations: _____

_____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement.)

10. DESIGNATION OF ALTERNATE AGENTS.

~~(You are not required to designate any alternate agents. You may designate one rather than two alternate agents if you desire.)~~

If the person designated as my agent in paragraph 1 is not available and willing to make a health care decision for me, then I designate and appoint the following persons to serve as ~~attorney-in-fact~~ my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate ~~Attorney-in-Fact~~ Agent _____

_____

(insert name and address of first alternate agent)

B. Second Alternate ~~Attorney-in-Fact~~ Agent _____

_____

(insert name and address of second alternate agent)

11. NOMINATION OF CONSERVATOR OF PERSON.

(A conservator of the person may be appointed for you if a court decides that one should be appointed. The conservator is responsible for your physical care, which may include making health care decisions for you. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE A PERSON TO SERVE AS YOUR CONSERVATOR IF A COURT DECIDES TO APPOINT ONE. You can nominate an individual as your conservator by completing the space below.)

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person _____

_____

(insert name and address of person nominated as conservator of the person)

(You are not required to designate any alternative agents but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1 above in the event that agent is unable or unwilling to act of your agent. Also, if the agent designated in paragraph 1 is your spouse, his or her designation as your agent is automat -5- ically revoked by law if your marriage is dissolved.)

12. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL (YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)
~~(THIS POWER OF ATTORNEY MUST BE DATED AND SIGNED BY THE PRINCIPAL.)~~

I sign my name to this Statutory Short Form Durable Power of Attorney for Health Care on _____ (Date) at _____ (City), _____ (State).

_____
(Signature of Principal)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS EITHER (1) ACKNOWLEDGED BEFORE A NOTARY PUBLIC IN CALIFORNIA OR (2) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO PERSONALLY KNOW YOU AND ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE.)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of California)
County of _____) ss.

On this _____ day of _____, in the year _____, before me, _____ (here insert name of notary public),

personally appeared _____ (here insert name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

_____
(Signature of Notary Public)

STATEMENT OF WITNESSES

(If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses and three would be preferable. None of the following may be used as a witness: (1) a person you designate as the agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury under the laws of California that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Signature: _____ Residence Address: _____

Print Name: _____ _____

_____

Signature: _____ Residence Address: _____

Print Name: _____ _____

_____

Signature: _____ Residence Address: _____

Print Name: _____ _____

_____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury under the laws of California that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Signature: _____

Signature: _____

SPECIAL REQUIREMENTS

(Check box if it applies to you. If you check a box, attach the required declaration or certificate.)

☐ Principal is a patient in a skilled nursing facility (as defined in Health and Safety Code Section 1250(c)). At least one witness is a patient advocate or ombudsman and has attached a declaration that he or she is serving as a witness as required by law.

☐ Principal is a conservatee under the Lanterman-Petris-Short Act, Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code, and the conservator is designated as the attorney-in-fact by this document. The principal is represented by legal counsel and the lawyer has attached his or her certificate containing the statement required by law.

Comment. Section 2500 is consistent with and subject to the substantive law applicable to a durable power of attorney for health care. See Sections 2430-2443. However, in the short form durable power of attorney for health care, the "warning" set out in Section 2500 replaces the one set out in Section 2433. See also Section 2501.