CALIFORNIA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. California maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://www.sos.ca.gov/registries/advance-health-care-directive-registry/

6. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **California Advance Health Care Directive,** that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete any or all of the first four parts, depending on your advance planning needs. You must complete part 5.

Part 1 is a **Power of Attorney for Health Care**. This part lets you name someone (an agent) to make decisions about your health care. Unless otherwise written in your advance directive, your power of attorney for health care becomes effective when your primary doctor determines that you lack the ability to understand the nature and consequences of your health care decisions or the ability to make and communicate your health care decisions. If you want your agent to make health care decisions for you now, even though you are still capable of making health care decisions, you can include this instruction in your power of attorney for health care designation.

Part 2 includes your **Individual Instructions**. This is your state's living will. It lets you state your wishes about health care in the event that you can no longer speak for yourself and you may limit the individual instructions to take effect only if a specified condition arises.

Part 3 allows you to express your wishes regarding organ donation.

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

Part 5 contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult, who is 18 years of age or older, or an emancipated minor.

INSTRUCTIONS FOR YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

How do I make my advance health care directive legal?

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself.

You r signature must be witnessed by or you must acknowledge your signature before a notary public or two adult witnesses. Your two adult witnesses may not be

- your health care provider or an employee of your health care provider,
- the operator or an employee of a community care facility,
- the operator or an employee of a residential care facility for the elderly, or
- the person you have appointed as an agent, if you have appointed an agent.

In addition, one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate.

If you are a patient in a skilled nursing facility when you execute your advance directive, one of your witnesses must be a patient advocate or ombudsman.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

Your agent cannot be

- your supervising health care provider,
- the operator of a community care facility or residential care facility where you are receiving care, or
- the employee of a health care institution where you are receiving care or employee of a community care facility or residential care facility where you are receiving care, <u>unless:</u>
    - the employee is related to you by blood, marriage, or adoption,
    - the employee is your registered domestic partner, or
    - the employee is your coworker at the facility or institution.

If you have a conservator appointed for you as part of involuntary commitment proceedings under the Lanterman-Petris-Short Act, that conservator cannot be appointed as your agent unless you are represented by a lawyer who signs a certificate stating that you have been advised of your rights. If this applies to you, you should talk with your lawyer about your rights, the applicable law, and the potential consequences involved.

On the other hand, you may include in your advance directive a nomination for the individual appointed as your conservator, if necessary. The court will consider your nomination in any protective proceeding.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling or unavailable to act for you.

Should I add personal instructions to my advance directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future health care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

Except for the appointment of your agent, you may revoke any portion or this entire advance directive at any time and in any way that communicates your intent to revoke. This could be by telling your agent or physician that you revoke, by signing a revocation, or simply by tearing up your advance directive.

In order to revoke your agent's appointment, you must either tell your supervising health care provider of your intent to revoke or revoke your agent's appointment in a signed writing.

If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

Unless you specify otherwise in Part 2, if you designate your spouse as your agent, that designation will automatically be revoked by divorce or annulment of your marriage.

What other important facts should I know?

Your agent, if you appoint one, does not have authority to authorize convulsive treatment, psychosurgery, sterilization, or abortion, or to have you committed or placed in a mental health treatment facility.

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make 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 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 an employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a co-worker. Your supervising health care provider can never act as your agent.)

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

Explanation Continued

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 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 in **Part 5**. The form must 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 and alternate agent(s) to make sure that he or she understands 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.

INSTRUCTIONS

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

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

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

_____
(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:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT (OPTIONAL)

_____
(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:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT (OPTIONAL)

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

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) AGENT'S AUTHORITY: My agent is authorized to make all 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.)

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(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.

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4, 5, OR 6 THAT DO NOT REFLECT YOUR WISHES

(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.

(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, in paragraph (2) above, or in Part 3 of this form:

_____

_____

_____

(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.

PART 2: INSTRUCTIONS FOR HEALTH CARE

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

(7) 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: (**Initial only one box**)

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

[ ] (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.

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

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT PAIN RELIEF OR COMFORT CARE

_____

_____

_____

_____

_____

_____

_____

_____

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(9) OTHER WISHES: (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.)

PART 3: DONATION OF ORGANS AT DEATH
(OPTIONAL)

ORGAN DONATION (OPTIONAL)

INITIAL THE BOX THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION

(10) Upon my death (initial applicable box):

[☐] (a) I do not give any of my organs, tissues, or parts and do not want my agent, conservator, or family to make a donation on my behalf,

[☐] (b) I give any needed organs, tissues, or parts,

OR

[☐] (c) I give the following organs, tissues, or parts only

_____

_____

_____

STRIKE THROUGH ANY USES YOU DO NOT AGREE TO

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

(1) Transplant
(2) Therapy
(3) Research
(4) Education

By checking the box above to give any organs, tissues or parts, or to give specified organs, tissues or parts only, 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.

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.

PART 4: PRIMARY PHYSICIAN
(OPTIONAL)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN (OPTIONAL)

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

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN (OPTIONAL)

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)

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

PART 5: EXECUTION

This Health Care Directive will not be valid unless it is EITHER:

(A) Signed by two (2) qualified adult witnesses who are personally known to you or to whom you have proven your identity by convincing evidence and who are present when you sign or acknowledge your signature. Your witnesses may not be

- your health care provider or an employee of your health care provider,
- the operator or an employee of a community care facility,
- the operator or an employee of a residential care facility for the elderly, or
- the person you have appointed as an agent, if you have appointed an agent.

In addition, one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate. (Use Alternative 1, below, if you decide to have your signature witnessed.)

OR

(B) Witnessed by a notary. (Use Alternative 2, below (page 12), if you decide to have your signature notarized.)

IF YOU CHOOSE TO SIGN WITH WITNESSES, USE ALTERNATIVE 1, BELOW

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW (PAGE 12)

THERE ARE SPECIAL WITNESSING REQUIREMENTS IF YOU LIVE IN A SKILLED NURSING FACILITY

If you are a patient in a skilled nursing facility when you execute your advance directive, one of your witnesses must be a patient advocate or ombudsman. This witness must sign the statement on page 13, even if you have had your advance directive notarized.

SIGN AND DATE THE DOCUMENT AND THEN PRINT YOUR NAME AND ADDRESS

WITNESSING PROCEDURE

BOTH OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

ONE WITNESS MUST ALSO SIGN THE STATEMENT ON PAGE 11

HAVE YOUR WITNESSES SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

OPTION 1: Sign before a Witness

_____ _____
(date) (sign your name)

_____
(print your name)

_____
(address)

_____
(city) (state) (zip code)

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 an 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:

_____ _____
(date) (signature of witness)

_____
(printed name of witness)

_____
(address)

_____
(city) (state) (zip code)

Second Witness:

_____ _____
(date) (signature of witness)

_____
(printed name of witness)

_____
(address)

_____
(city) (state) (zip code)

ONE OF YOUR WITNESSES MUST ALSO SIGN THIS STATEMENT

ADDITIONAL WITNESS STATEMENT

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____ _____

(date) (signature of witness)

SIGN AND DATE THE DOCUMENT AND THEN PRINT YOUR NAME AND ADDRESS

A NOTARY PUBLIC MUST FILL OUT THIS PORTION OF THE FORM

ACKNOWLEDGMENT

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,_____
(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.

Signature _____ **(Seal)**

THIS SECTION MUST BE COMPLETED BY A PATIENT ADVOCATE OR OMBUDSMAN IF YOU ARE A RESIDENT IN A SKILLED NURSING FACILITY

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 witness as required by section 4675 of the Probate Code.

_____ _____

(date) (signature)

_____

(printed name)

_____

(address)

_____

(city) (state) (zip code)

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your *California Advance Health Care Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. California maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://www.sos.ca.gov/registries/advance-health-care-directive-registry/

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your California document.

8. Be aware that your California document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

GuideStar Exchange GOLD

OR donate online today: www.NationalHospiceFoundation.org/donate

Instrucción anticipada de atención de salud de California

California Advance Health Care Directive

SPANISH & ENGLISH

- Esta forma les permitirá a sus médicos conocer sus deseos de cuidado de la salud
  This form will let your doctors know your health care wishes
- Esta forma tiene 2 tipos de páginas
  This form has 2 types of pages

  Las páginas de la izquierda están en español e inglés
  Pages on the left have both Spanish and English

  Las páginas de la derecha están solamente en español
  Pages on the right have only Spanish

  Ambas páginas dicen **lo mismo**
  Both pages say the **same thing**
- La mayoría de los médicos solamente habla inglés
  Most doctors only read English

  Por lo tanto, llene solamente las páginas que están en inglés y español
  So only fill out pages that have both Spanish and English
- Si necesita ayuda, llame al 408-332-5579
  If you need help call 408-332-5579

ESPAÑOL

- Esta forma les permitirá a sus médicos conocer sus deseos de cuidado de la salud
- Esta forma tiene 2 tipos de páginas

  Las páginas de la izquierda están en español e inglés

  Las páginas de la derecha están solamente en español

  Ambas páginas dicen **lo mismo**
- La mayoría de los médicos solamente habla inglés

  Por lo tanto, llene solamente las páginas que están en inglés y español
- Si necesita ayuda, llame al 408-332-5579

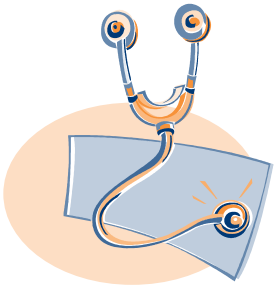
Vaya a la página siguiente
Go to the next page

Instrucción anticipada de atención de salud de California

California Advance Health Care Directive

Esta forma le permite indicar cómo desea que le traten si está muy enfermo.

This form lets you have a say about how you want to be treated if you get very sick.



Esta forma consta de 3 partes. Le permite:

This form has 3 parts. It lets you:

Parte 1: Escoger un apoderado de atención de salud.

Part 1: Choose a health care agent.

Un apoderado de atención de salud es una persona que puede tomar decisiones médicas por usted si está muy enfermo para tomarlas por usted mismo.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

Parte 2: Tomar sus propias decisiones de atención de salud.

Part 2: Make your own health care choices.

Esta forma le permite escoger el tipo de atención de salud que desea. De esta manera, las personas encargadas de su cuidado no tendrán que adivinar lo que desea si está muy enfermo para decirlo por usted mismo.

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Parte 3: Firmar el formulario.

Part 3: Sign the form.

Se debe firmar antes de que se pueda usar.

It must be signed before it can be used.

Usted puede llenar la Parte 1, la Parte 2 o ambas. Siempre firme el formulario en la página E9.

You can fill out Part 1, Part 2, or both. Always sign the form on page E9.

Es necesario que 2 testigos firmen en la página E10 o que un notario público firme en la página E11.

2 witnesses need to sign on page E10 or a notary public on page E11.

SU NOMBRE: _____

YOUR NAME:

Vaya a la página siguiente
Go to the next page

Si sólo desea un apoderado de atención de salud, vaya a la Parte 1 en la página E3.

If you only want a health care agent, go to Part 1 on page E3.

Si sólo desea tomar sus propias decisiones de atención de salud, vaya a la Parte 2 en la página E6.

If you only want to make your own health care choices, go to Part 2 on page E6.

Si desea hacer ambas cosas, llene la Parte 1 y la Parte 2.

If you want both, then fill out Part 1 and Part 2.

Siempre firme el formulario en la Parte 3 que está en la página E9.

Always sign the form in Part 3 on page E9.

Es necesario que 2 testigos firmen en la página E10 o que un notario público firme en la página E11.

2 witnesses need to sign on page E10 or a notary public on page E11.

¿Qué hago con el formulario después de llenarlo?

What do I do with the form after I fill it out?

Compártalo con aquellos encargados de su cuidado:

Share the form with those who care for you:

- médicos doctors
- enfermeras nurses
- trabajadores sociales social workers
- familiares y amigos family & friends
- apoderado de atención de salud health care agent

¿Qué sucede si cambio de opinión?

What if I change my mind?

- Debe llenar un formulario nuevo. Fill out a new form.
- Informe sobre los cambios a aquellos encargados de su cuidado.
  Tell those who care for you about your changes.
- Entregue el formulario nuevo a su apoderado de atención de salud y a su médico. Give the new form to your health care agent and doctor.

¿Qué sucede si tengo preguntas sobre el formulario?

What if I have questions about the form?

- Haga las preguntas que usted tenga a los médicos, enfermeras, trabajadores sociales, apoderados de atención de salud, familiares o amigos para que se las respondan.
  Bring it to your doctors, nurses, social workers, health care agent, family or friends to answer your questions.

¿Qué sucede si tengo decisiones de atención de salud que no aparecen en esta forma?

What if I want to make health care choices that are not on this form?

- Escriba sus decisiones en una hoja adicional.
  Write your choices on a piece of paper.
- Guarde la hoja junto a esta forma.
  Keep the paper with this form.
- Comparta sus decisiones con aquellos encargados de su cuidado.
  Share your choices with those who care for you.

PARTE 1 Escoger un apoderado de atención de salud

PART 1 Choose your health care agent

La persona que puede tomar decisiones médicas por usted si está muy enfermo para tomarlas por usted mismo.

The person who can make medical decisions for you if you are too sick to make them yourself.

¿A quién debo escoger como mi apoderado de atención de salud?

Whom should I choose to be my health care agent?

Un familiar o amigo que:

A family member or friend who:

- tenga como mínimo 18 años
  is at least 18 years old
- le conozca bien
  knows you well
- pueda estar con usted cuando lo necesite
  can be there for you when you need them
- usted confíe que hará lo mejor para usted
  you trust to do what is best for you
- pueda informarle a los médicos sobre las decisiones que tomó en esta forma
  can tell your doctors about the decisions you made on this form

Su apoderado no puede ser su médico o alguien que trabaje en el hospital o clínica, a menos que sea un familiar.

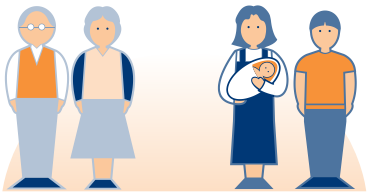
Your agent cannot be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.

¿Qué sucede si no escojo un apoderado de atención de salud?

What will happen if I do not choose a health care agent?

Si está demasiado enfermo como para tomar sus propias decisiones, los médicos les pedirán a sus familiares más directos que tomen las decisiones por usted.

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.



Si desea que su apoderado no sea un familiar, debe escribir su nombre en esta forma.

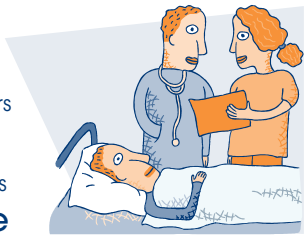
If you want your agent to be someone other than family, you must write his or her name on this form.

¿Qué tipo de decisiones puede tomar mi apoderado de atención de salud?

What kind of decisions can my health care agent make?

Aceptar, rechazar, cambiar, suspender o escoger:

Agree to, say no to, change, stop or choose:



- médicos, enfermeras, trabajadores sociales — doctors, nurses, social workers
- hospitales o clínicas — hospitals or clinics
- medicamentos, exámenes o tratamientos — medications, tests, or treatments
- lo que sucederá con su cuerpo y órganos después de su muerte
  what happens to your body and organs after you die

Su apoderado deberá seguir las decisiones de atención de salud que usted tome en la Parte 2. Your agent will need to follow the health care choices you make in Part 2.

Vaya a la página siguiente
Go to the next page

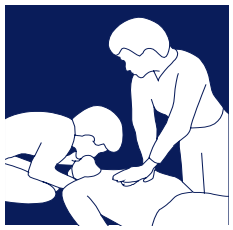
Otras decisiones que su apoderado puede tomar:

Other decisions your agent can make:

Tratamientos de soporte vital – tratamiento médico para ayudarle a vivir más tiempo

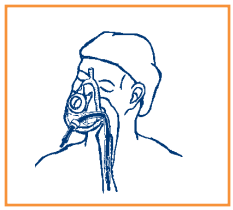
Life support treatments – medical care to try to help you live longer

- **RCP o reanimación cardiopulmonar (cardiopulmonary resuscitation)**
  cardio = corazón (heart) • pulmonar = pulmones (lungs) • reanimación = recuperación (to bring back)



Estos tratamientos pueden ser: This may involve:

- presionar con fuerza en el pecho para mantener la circulación de la sangre pressing hard on your chest to keep your blood pumping
- choques eléctricos para hacer que el corazón vuelva a funcionar electrical shocks to jump start your heart
- medicamentos a través de las venas medicines in your veins



- **Respirador artificial** Breathing machine or ventilator

  El respirador bombea aire a los pulmones y respira por usted. Usted no puede hablar cuando se encuentra conectado al respirador.
  The machine pumps air into your lungs and breathes for you. You are not able to talk when on the machine.

- **Diálisis** Dialysis

  Una máquina que limpia la sangre si los riñones dejan de funcionar.
  A machine that cleans your blood if your kidneys stop working.

- **Sonda de alimentación** Feeding tube

  Una sonda que se usa para alimentarle si no puede tragar. Esta sonda se inserta por la garganta hasta el estómago. También se puede colocar mediante una cirugía.
  A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

- **Transfusiones de sangre** Blood transfusions

  Poner sangre en las venas. To put blood in your veins.

- **Cirugía** Surgery
- **Medicamentos** Medicines

Cuidados para el final de la vida – si existe la posibilidad de que muera pronto, su apoderado de atención de salud puede:

End of life care – if you might die soon your health care agent can:

- llamar a un guía espiritual
  call in a spiritual leader
- decidir si muere en su casa o en el hospital
  decide if you die at home or in the hospital

Comparta esta forma con su apoderado de atención de salud.
Dígale a su apoderado el tipo de tratamiento médico que desea.

Show your health care agent this form. Tell your agent what kind of medical care you want.

Vaya a la página siguiente
Go to the next page

Su representante de atención médica

Your Health Care Agent

Deseo que esta persona tome por mí las decisiones relacionadas con la atención médica. Escriba esto en la página E5. I want this person to make my medical decisions. Write this on page E5.

nombre (first name) _____ apellido (last name) _____

dirección (street address) _____ ciudad (city) _____ estado (state) _____ código postal (zip code) _____

( ) _____ – ( ) _____ –

número de teléfono particular (home phone number) _____ número de teléfono del trabajo (work phone number) _____

Si esta primera persona no puede hacerlo, deseo que esta otra persona tome por mí las decisiones relacionadas con la atención médica. If the first person cannot do it, then I want this person to make my medical decisions.

nombre (first name) _____ apellido (last name) _____

dirección (street address) _____ ciudad (city) _____ estado (state) _____ código postal (zip code) _____

( ) _____ – ( ) _____ –

número de teléfono particular (home phone number) _____ número de teléfono del trabajo (work phone number) _____

Marque con una X la oración con la que está de acuerdo. Marque esto en la página E5.
Put an X next to the sentence you agree with. Mark this on page E5.

- ☐ Mi representante de atención médica puede tomar decisiones por mí inmediatamente después de que yo firme este formulario. My health care agent can make decisions for me right after I sign this form.
- ☐ Mi representante de atención médica puede tomar decisiones por mí **solamente** cuando yo no pueda tomar mis propias decisiones. My health care agent will make decisions for me **only** after I cannot make my own decisions.

Puede escribir en este formulario sus elecciones relacionadas con la atención médica. ¿Cómo desea que su representante de atención médica cumpla estas elecciones? Marque con una X una oración con la que más esté de acuerdo. Marque esto en la página E5.
You may write down your health care choices on this form. How do you want your health care agent to follow these choices? Put an X next to the one sentence you most agree with. Write this on page E5.

- ☐ Deseo que mi representante de atención médica tome decisiones junto con mis médicos de acuerdo con su criterio. Acepto que mi representante cumpla mis elecciones de atención médica que figuran en este formulario como una **pauta general**.
  I want my health care agent to work with my doctors and to use her/his best judgment. It is OK for my agent to follow my health care choices on this form as a general guide.

  A pesar de que acepto que se cumplan mis elecciones de atención médica como una pauta general, hay algunas elecciones que no deseo cambiar:
  Even though it is OK to follow my choices as a general guide, there are some choices I do not want changed:

  _____

  _____

- ☐ Deseo que mi representante siga mis elecciones de atención médica **exactamente** tal como están expresadas en este formulario. Nunca deseo que mi representante cambie mis elecciones, aunque los médicos consideren que no son buenas para mí.
  I want my health care agent to follow my health care choices on this form exactly. I never want my agent to change my choices, even if the doctors think this is not good for me.

Para tomar sus propias decisiones de atención de salud, vaya a la Parte 2 en la página siguiente.
To make your own health care choices, go to Part 2 on the next page.

Para firmar esta forma, vaya a la Parte 3 en la página E9.
To sign this form, go to Part 3 on page E9.

PARTE 2 Tomar sus propias decisiones de atención de salud

PART 2 Make your own health care choices

Escriba sus decisiones de manera que aquellos encargados de su cuidado no tengan que adivinar. Escriba sus decisiones en la página E6.

Write down your choices so those who care for you will not have to guess. Write your answers on page E6.

Piense en las cosas que hacen que su vida valga la pena.

Think about what makes your life worth living.

❑ **Mi vida sólo vale la pena si puedo:**

My life is only worth living if I can:

Marque con una X todas las frases con las cuales esté de acuerdo en la página E6.

Put an X next to all the sentences you agree with on page E6.

- ❍ conversar con mi familia o amigos — talk to family or friends
- ❍ despertar de un estado de coma — wake up from a coma
- ❍ alimentarme, bañarme y cuidar de mí mismo — feed, bathe, or take care of myself
- ❍ no sentir dolor — be free from pain
- ❍ vivir sin estar conectado a máquinas — live without being hooked up to machines
- ❍ no estoy seguro — I am not sure

O or

❑ **Mi vida siempre vale la pena sin importar lo enfermo que esté.**

My life is always worth living no matter how sick I am.

Si estoy muriendo, es importante para mí estar:

If I am dying, it is important for me to be:

❑ en casa — at home ❑ en el hospital — in the hospital ❑ no estoy seguro — I am not sure

¿Es importante para usted la religión o la espiritualidad?

Is religion or spirituality important to you?

❑ no — no ❑ sí — yes

Si usted tiene una religión… ¿Cuál es?

If you have one, what is your religion? _____

¿Qué deben saber los médicos sobre su religión o espiritualidad?

What should your doctors know about your religion or spirituality?

_____

_____

Si está enfermo, sus médicos y enfermeras siempre intentarán mantenerle lo más cómodo posible y sin dolor.

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

Vaya a la página siguiente
Go to the next page

Los tratamientos de soporte vital se usan para mantenerle vivo. Estos pueden ser RCP, un respirador artificial, sondas de alimentación, diálisis, transfusiones de sangre o medicamentos.

Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Marque con una X la frase con la cual esté más de acuerdo.

Por favor, lea toda esta página antes de tomar sus decisiones.

Marque sus respuestas en la página E7.

Put an X next to the one choice you most agree with.

Please read this whole page before you make your choice.

Mark your answers on page E7.

Si estoy muy enfermo y puedo morir pronto:

If I am so sick that I may die soon:

☐ Deseo que se intenten todos los tratamientos de soporte vital que mis médicos crean que pueden ayudar.
Try all life support treatments that my doctors think might help.

Si los tratamientos **no funcionan** y existe una mínima esperanza de mejorarme, **deseo que me conecten** a máquinas de soporte vital.
If the treatments **do not work** and there is little hope of getting better, **I want to stay** on life support machines.

Or

☐ Deseo que se intenten todos los tratamientos de soporte vital que mis médicos crean que pueden ayudar.
Try all life support treatments that my doctors think might help.

Si los tratamientos **no funcionan** y existe una mínima esperanza de mejorarme, **no deseo que me conecten** a máquinas de soporte vital.
If the treatments **do not work** and there is little hope of getting better, **I do not want to stay** on life support machines.

Or

☐ Deseo que se intenten todos los tratamientos de soporte vital que mis médicos crean que pueden ayudar, **pero no** los siguientes.
Try all life support treatments that my doctors think might help **but not** these treatments.

Marque los tratamientos que **no desee**.
Mark what you do not want.

- ○ RPC CPR
- ○ diálisis dialysis
- ○ respirador artificial breathing machine
- ○ sonda de alimentación feeding tube
- ○ transfusión de sangre blood transfusion
- ○ medicamentos medicine
- ○ otros tratamientos other treatments _____

Or

☐ **No deseo ningún** tratamiento de soporte vital.
I **do not want any** life support treatments.

Or

☐ Deseo que mi **apoderado de atención de salud** decida por mí.
I want my **health care agent** to decide for me.

Or

☐ No estoy seguro.
I am not sure.

Vaya a la página siguiente
Go to the next page

Sus médicos pueden preguntar sobre la donación de órganos y autopsia después de morir. Infórmenos sus deseos.

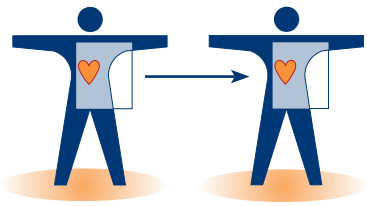
Your doctors may ask about organ donation and autopsy after you die. Please tell us your wishes.

Marque con una X la frase con la cual esté más de acuerdo. Put an X next to the one choice you most agree with.

Marque sus respuestas en la página E8. Mark your answers on page E8.

Donar (dar) sus órganos puede ayudar a salvar vidas.

Donating (giving) your organs can help save lives.



- ❑ **Deseo** donar mis órganos.
  I **want** to donate my organs.

  ¿Qué órganos desea donar?
  Which organs do you want to donate?

  - ❍ cualquier órgano any organ
  - ❍ sólo only _____

- ❑ **No deseo** donar mis órganos.
  I **do not** want to donate my organs.
- ❑ Deseo que mi **apoderado de atención de salud** decida.
  I want my **health care agent** to decide.
- ❑ No estoy seguro.
  I am not sure.

Se puede realizar una autopsia después de la muerte para saber por qué murió una persona.

An autopsy can be done after death to find out why someone died.

Se realiza mediante una cirugía. Puede tardar algunos días.

It is done by surgery. It can take a few days.

- ❑ **Deseo** una autopsia.
  I **want** an autopsy.
- ❑ **No deseo** una autopsia.
  I **do not want** an autopsy.
- ❑ Deseo una autopsia si existe alguna duda sobre mi muerte.
  I **want** an autopsy if there are questions about my death.
- ❑ Deseo que mi **apoderado de atención de salud** decida.
  I want my **health care agent** to decide.
- ❑ No estoy seguro.
  I am not sure.

¿Qué deben saber sus médicos sobre la forma en que desea se trate su cuerpo después de que muera?

What should your doctors know about how you want your body to be treated after you die?

_____

_____

Vaya a la Parte 3 en la página siguiente para firmar esta forma
Go to Part 3 on the next page to sign this form

PARTE 3 Firmar el formulario en la página E9

PART 3 Sign the form on page E9

Antes de que se pueda usar esta forma, usted debe:
Before this form can be used, you must:

- Firmar el formulario en la página E9. Sign the form on pae E9.
- Pedirles a dos testigos que lo firmen en la página E10. Have two witnesses sign on page E10.

Si usted no tiene testigos, un notario público debe firmar en la página E11.

El trabajo del notario público es asegurarse de que sea usted quien firma el formulario.
If you do not have witnesses, a notary public must sign on page E11. A notary public's job is to make sure it is you signing the form.

Firme e indique la fecha en la página E9. Sign your name and write the date on page E9.

firma (sign your name) _____ fecha (date) ___/___/___

nombre en letra de molde (print your first name) _____ apellido en letra de molde (print your last name) _____

dirección (street address) _____ ciudad (city) _____ estado (state) _____ código postal (zip code) _____

Su testigo debe: Your witnesses must:

- ser mayor de 18 años be over 18 years of age
- conocerle a usted know you
- verle firmar esta forma see you sign this form

Su testigo no puede: Your witnesses cannot:

- ser su apoderado de atención de salud be your health care agent
- ser su proveedor de atención de salud be your health care provider
- trabajar para su proveedor de atención de salud work for your health care provider
- trabajar en el lugar donde usted vive (si usted vive en una casa de reposo, vaya a la página E12) work at the place that you live (if you live in a nursing home go to page E12)

Además, los testigos no pueden: Also, one witness cannot:

- estar relacionados con usted de ningún modo be related to you in any way
- beneficiarse financieramente (recibir dinero o propiedades) después de su muerte
  benefit financially (get any money or property) after you die

Los testigos tienen que firmar en la página E10. Witnesses need to sign their names on page E10.

Si no tiene testigos, lleve esta forma a un notario público y pídale que firme en la página E11.
If you do not have witnesses, take this form to a notary public and have them sign on page E11.

Pídale a sus testigos que firmen e indiquen la fecha en la página E10

Have your witnesses sign their names and write the date on page E10

Por medio de mi firma, doy fe que _____ (nombre) firmó esta forma mientras yo le miraba. By signing, I promise that _____ (name) signed this form while I watched.

Esta persona tenía un uso pleno de su capacidad mental y no fue forzada a firmarlo. He/she was thinking clearly and was not forced to sign it.

También doy fe de que: I also promise that:

- Conozco a esta persona o esta persona demostró quién era — I know him/her or this person could prove who he/she was
- Soy mayor de 18 años — I am 18 years or older
- No soy su apoderado atención de salud — I am not his/her health care agent
- No soy su proveedor de cuidado de la salud — I am not his/her health care provider
- No trabajo para su proveedor de cuidado de la salud — I do not work for his/her health care provider
- No trabajo en el lugar donde vive esta persona — I do not work where he/she lives

Uno de los testigos también debe dar fe de lo siguiente: One witness must also promise that:

- No tengo un parentesco de sangre, por matrimonio ni adopción — I am not related to him/her by blood, marriage, or adoption
- No recibiré un beneficio económico (dinero o propiedades) después de que esta persona muera — I will not benefit financially (get any money or property) after he/she dies

Testigo 1: Firmen en la página E10. Witness #1: Sign on page E10.

firma (sign your name) _____ fecha (date) ___/___/___

nombre en letra de molde (print your first name) _____ apellido en letra de molde (print your last name) _____

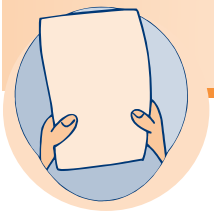
dirección (street address) _____ ciudad (city) _____ estado (state) _____ código postal (zip code) _____

Testigo 2: Firmen en la página E10. Witness #2: Sign on page E10.

firma (sign your name) _____ fecha (date) ___/___/___

nombre en letra de molde (print your first name) _____ apellido en letra de molde (print your last name) _____

dirección (street address) _____ ciudad (city) _____ estado (state) _____ código postal (zip code) _____



Ha terminado de llenar esta forma.

You are now done with this form.

Comparta esta forma con sus médicos, enfermeras, trabajadores sociales, amigos, familiares y su apoderado de atención de salud.

Share this form with your doctors, nurses, social workers, friends, family, and health care agent.

Converse con ellos sobre sus decisiones.

Talk with them about your choices.

NOTARIO PÚBLICO

Notary Public

- Lleve esta forma a un notario público **SOLAMENTE** si no lo han firmado dos testigos.
  Take this form to a notary public only if two witnesses have not signed this form.
- Lleve una identificación con fotografía (licencia de conducir, pasaporte, etc.)
  Bring photo I.D. (driver's license, passport, etc.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California

County of _____

On _____ (Date) before me, _____ (Here insert name and title of the officer), personally appeared _____ (Name(s) of Signer(s))

_____,

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.

Signature _____ (Signature of Notary Public)

Description of Attached Document
Title or Type of document: _____
Date: _____ Number of pages: _____

Capacity(ies) Claimed by Signer(s)
Signer's Name: _____
☐ Individual
☐ Guardian or conservator
☐ Other _____

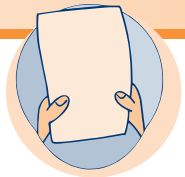
RIGHT THUMBPRINT OF SIGNER
Top of thumb here

(Notary Seal)

Ha terminado de llenar esta forma.

You are now done with this form.

Comparta esta forma con sus médicos, enfermeras, trabajadores sociales, amigos, familiares y su apoderado de atención de salud.
Share this form with your doctors, nurses, social workers, friends, family, and health care agent.



Converse con ellos sobre sus decisiones.
Talk with them about your choices.

SÓLO para residentes de casas de reposo del estado de California

For California Nursing Home Residents ONLY

- **Entréguele esta forma al director de su casa de reposo, sólo si vive en una.**
  Give this form to your nursing home director **only** if you live in a nursing home.

- **La ley de California exige que los residentes de las casas de reposo tengan al mediador público (ombudsman) como testigo de las instrucciones anticipadas.**
  California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

DECLARACIÓN DEL DEFENSOR LEGAL (OMBUDSMAN) DEL PACIENTE

STATEMENT OF THE PATIENT ADVOCATE OR OMBUDSMAN

"Declaro bajo pena de perjurio en conformidad con las leyes del estado de California que soy el defensor o mediador público (ombudsman) designado por el Departamento Estatal de la Tercera Edad y que actúo como testigo según lo estipulado en la Sección 4675 del Código de Sucesiones."

"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."

/ /

firma (sign your name) fecha (date)

nombre en letra de molde (print your first name) apellido en letra de molde (print your last name)

dirección (street address) ciudad (city) estado (state) código postal (zip code)

Estas instrucciones anticipadas cumplen con el Código de Sucesiones de California, Sección 4671-4675.
http://www.leginfo.ca.gov/calaw.html

This advance directive is in compliance with the California Probate Code, Section 4671-4675. http://www.leginfo.ca.gov/calaw.html

E12

Revisado el 1/18/2010

Diseñado por Rebecca Sudore, MD & Mahat Papartassee para el Departamento de Salud Pública de San Francisco
Designed by Rebecca Sudore, MD & Mahat Papartassee for the San Francisco Department of Public Health

簡易中英文
Easy English-Chinese

加州醫療照護事前指示

California Advance Health Care Directive

CHINESE & ENGLISH

- 這份指示書將會讓您的醫生明白您的醫護服務意願
  This form will let your doctors know your health care wishes
- 這份指示書有兩種類型的頁面
  This form has 2 types of pages

  左邊的頁面同時具有中文和英文
  Pages on the left have both Chinese and English

  右邊的頁面只具有中文
  Pages on the right have only Chinese

  兩種頁面的內容**完全相同**
  Both pages say the same thing
- 大部分的醫生只能閱讀英文
  Most doctors only read English

  所以請您只需要填寫同時具有中文和英文的頁面
  So only fill out pages that have both Chinese and English
- 如果您需要人幫忙填寫，請致電 408-332-5579
  If you need help call 408-332-5579

中文

- 這份指示書將會讓您的醫生明白您的醫護服務意願
- 這份指示書有兩種類型的頁面

  左邊的頁面同時具有中文和英文

  右邊的頁面只具有中文

  兩種頁面的內容**完全相同**
- 大部分的醫生只能閱讀英文

  所以請您只需要填寫同時具有中文和英文的頁面
- 如果您需要人幫忙填寫，請致電 408-332-5579

請翻到下頁
Go to the next page

加州醫療照護事前指示

California Advance Health Care Directive

這份指示書讓您可事前表達在病重時希望得到何種的療護。

This form lets you have a say about how you want to be treated if you get very sick.

本指示書分爲三部份。它可讓您：

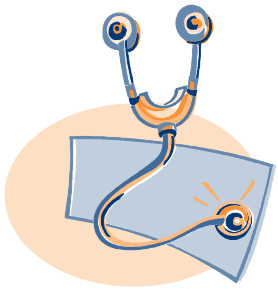
This form has 3 parts. It lets you:

第一部份： **選擇一位醫療代理人。**

Part 1: Choose a health care agent.

在您病重無法做任何醫療決定時，醫療代理人會為您做決定。

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.



第二部份： **自己做醫療決定。**

Part 2: Make your own health care choices.

本指示書讓您選擇自己想要的各項醫護服務。

This form lets you choose the kind of health care you want.

如此一來，若您病得太重而無法表達意見時，醫護人員及親友們就不用去猜測您的心意。

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

第三部份： **簽署指示書。**

Part 3: Sign the form.

這份指示書必須簽字才會生效。 It must be signed before it can be used.

您可填寫第一部份或第二部份，或兩部份均填寫。您一定要在英文的第九頁(E9)簽名。

You can fill out Part 1, Part 2, or both. Always sign the form on page E9.

兩位見證人需在英文的第十頁(E10)簽名，或是一位公證人在英文的第十一頁(E11)簽名。

2 witnesses need to sign on page E10 or a notary public on page E11.

你的名字: _____

Your name:

請翻到下頁

Go to the next page

如果您只想指定醫療代理人，請翻到英文第3頁(E3)第一部份。

If you only want a health care agent, go to Part 1 on page E3.

如果您只想自行選擇醫療決定，請翻到英文第6頁(E6)第二部份。

If you only want to make your own health care choices, go to Part 2 on page E6.

如果您希望兩項都指定，請填寫第一部份和第二部份。

If you want both, then fill out Part 1 and Part 2.

請您務必記得在英文第9頁(E9)第三部份簽名。

Always sign the form in Part 3 on page E9.

兩位見證人需在英文的第十頁(E10)簽名，或由一位公證人在英文的第十一頁(E11)簽名。

2 witnesses need to sign on page E10 or a notary public on page E11.

填妥指示書後，該如何處理 ？

What do I do with the form after I fill it out?

請將指示書影本給：

Share the form with those who care for you:

- 醫生 doctors
- 護士 nurses
- 社工 social workers
- 家人和朋友 family & friends
- 醫療代理人 health care agent

如果我改變主意，該怎麼辦？

What if I change my mind?

- 重新填寫一份指示書。 Fill out a new form.
- 把修改的內容告訴照顧您的人。 Tell those who care for you about your changes.
- 把新的指示書給您的醫療代理人和醫生。 Give the new form to your health care agent and doctor.

如果對指示書有疑問，該怎麼辦？

What if I have questions about the form?

- 把指示書拿給您的醫生、護士、社工人員、醫療代理人、家人或朋友，由他們為您解答。

  Bring it to your doctors, nurses, social workers, health care agent, family or friends to answer your questions.

如果本指示書沒有我想要的醫療決定，該怎麼做？

What if I want to make health care choices that are not on this form?

- 請將您的意願寫在一張紙上。

  Write your choices on a piece of paper.
- 寫好後和指示書放在一起。

  Keep the paper with this form.
- 與醫護人員及親友們討論附頁內容。

  Share your choices with those who care for you.

第一部份 選擇您的醫療代理人

PART 1 Choose your health care agent

您的醫療代理人會在您病重不能為自己作決定時，替您選擇各項醫療服務

The person who can make medical decisions for you if you are too sick to make them yourself.

我應該選擇誰當我的醫療代理人？

Whom should I choose to be my health care agent?

符合下列條件的家人或朋友：

A family member or friend who:

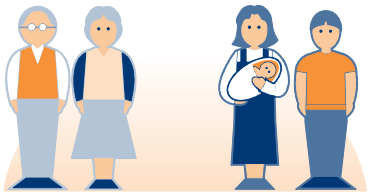
- 年滿 18 歲
  is at least 18 years old
- 非常了解您
  knows you well
- 有需要時可聯絡到您
  can be there for you when you need them
- 您信任會為您作最好的決定
  you trust to do what is best for you
- 能告訴醫生您在指示書中所做的決定
  can tell your doctors about the decisions you made on this form

您的醫療代理人不可以是您的醫生、醫院或診所的工作人員，除非他(她)是您的家人。

Your agent cannot be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.

如果我沒有選擇醫療代理人，會發生什麼狀況?

What will happen if I do not choose a health care agent?



當您重病而不能自己做決定時，醫生會請您最親的家屬為您做決定。

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.

如果您希望由親屬以外的人當您的代理人，必須把他（她）的名字寫在指示書裡。

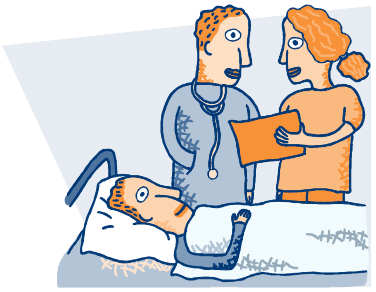
If you want your agent to be someone other than family, you must write his or her name on this form.

我的醫療代理人可以做什麼樣的決定？

What kind of decisions can my health care agent make?

他（她）可以為您同意、拒絕、改變、停止或選擇：

Agree to, say no to, change, stop or choose:



- 醫生、護士、社工 doctors, nurses, social workers
- 醫院或診所 hospitals or clinics
- 藥物，檢測，或治療 medications, tests, or treatments
- 如何處理您的遺體與器官 what happens to your body and organs after you die

您的醫療代理人需要遵照您在第二部份中的醫療意願。

Your agent will need to follow the health care choices you make in Part 2.

請翻到下頁
Go to the next page

您的代理人還可以替您作什麼決定:

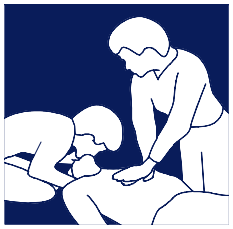
Other decisions your agent can make:

維持生命的治療 – 嘗試延長您的生命的醫療方法

Life support treatments – medical care to try to help you live longer

- **心肺復甦術 (cardiopulmonary resuscitation)，簡稱 CPR**

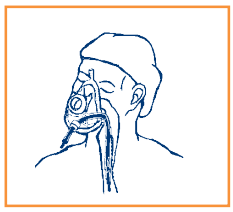
cardio = 心臟 (heart) • pulmonary = 肺臟 (lungs) • resuscitation = 復甦 (to bring back)



包括了：

This may involve:

- 用力擠壓胸膛，使心臟維持輸送血液功能
  pressing hard on your chest to keep your blood pumping
- 透過電擊讓心臟再度跳動
  electrical shocks to jump start your heart
- 把藥物注射到靜脈裡
  medicines in your veins



- **呼吸輔助器** Breathing machine or ventilator
  呼吸輔助器把氧氣輸入肺部，協助病人呼吸。 使用期間病人不能說話。
  The machine pumps air into your lungs and breathes for you.
  You are not able to talk when you are on the machine.
- **血液透析術 (洗腎)** Dialysis
  腎臟功能喪失時，用洗腎機來過濾血液。
  A machine that cleans your blood if your kidneys stop working.
- **餵食管** Feeding Tube
  病人無法吞嚥時要靠餵食管來進食。餵食管可從喉嚨插入胃部；或以手術插置餵食管。
  A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

- **輸血** Blood transfusions
  從靜脈輸入血液。
  To put blood in your veins.
- **外科手術 (開刀)** Surgery
- **藥物** Medicines

生命末期服務 – 生命末期，醫療代理人可以：

End of life care – if you might die soon your health care agent can:

- 邀請宗教輔導員到場
  call in a spiritual leader
- 決定在家裡或在醫院離世
  decide if you die at home or in the hospital

請把本指示書給您的醫療代理人。告訴您的代理人您想接受哪一種醫療照顧。

Show your health care agent this form. Tell your agent what kind of medical care you want.

請翻到下頁
Go to the next page

您的醫療代理人

Your Health Care Agent

本人希望下列人士替我作醫療抉擇。請在英文第五頁(E5)上填寫。
I want this person to make my medical decisions. Write this on page E5.

名字 (first name) 姓氏 (last name)

地址 (street address) 城市 (city) 州 (state) 郵區號碼 (zip code)

( ) – ( ) –

住宅電話號碼 (home phone number) 工作電話號碼 (work phone number)

如果以上指定的人不能代辦，我希望下列人士替我作醫療抉擇。
If the first person cannot do it, then I want this person to make my medical decisions.

名字 (first name) 姓氏 (last name)

地址 (street address) 城市 (city) 州 (state) 郵區號碼 (zip code)

( ) – ( ) –

住宅電話號碼 (home phone number) 工作電話號碼 (work phone number)

請在您同意的句子旁劃一個X。請在英文第五頁(E5)上打X。
Put an X next to the sentence you agree with. Mark this on page E5.

☐ 在我簽署這份指示書後，我的醫療代理人就可以替我做決定。
My health care agent can make decisions for me right after I sign this form.

☐ 我的醫療代理人只有在我無法自己做決定時，**才能**替我做決定。
My health care agent will make decisions for me **only** after I cannot make my own decisions.

您可以在本指示書上寫下您的醫療選擇。您希望您的醫療代理人如何遵照這些選擇？請在您最同意的<u>一個</u>句子旁劃一個X。請在英文第五頁(E5)上打X。
You may write down your health care choices on this form. How do you want your health care agent to follow these choices? Put an X next to the <u>one</u> sentence you most agree with. Write this on page E5.

☐ 我希望我的醫療代理人能與我的醫生配合，並盡他（她）最佳的判斷能力。我的代理人可以把我在本指示書上所寫的醫療選擇視為<u>基本指南</u>來遵守。
I want my health care agent to work with my doctors and to use her/his best judgment. It is OK for my agent to follow my health care choices on this form as a <u>general guide</u>.

雖然說可以把我的選擇視為基本指南來遵守，但我還是希望以下的抉擇不要被改變：
Even though it is OK to follow my choices as a general guide, there are some choices I do not want changed:

☐ 我希望我的醫療代理人要<u>完全</u>遵守我在本指示書上的醫療選擇。即使連醫生也認為這選擇對我並沒有好處，我的代理人也絕對不可以改變我的選擇。
I want my health care agent to follow my health care choices on this form <u>exactly</u>. I never want my agent to change my choices, even if the doctors think this is not good for me.

要選擇自己的醫護服務，請翻到下頁的第二部份。
To make your own health care choices, go to Part 2 on the next page.

只要簽署指示書，請翻到英文第9頁(E9)第三部份。
To sign this form, go to Part 3 on page E9.

Note: Pages E1-E4 contain educational materials only.

第二部份 自行做醫療照顧的選擇

PART 2 Make your own health care choices

請寫下您的決定，這樣醫護人員及親友們才不用去猜測您的想法。請在英文第六頁(E6)上作出您的選擇。
Write down your choices so those who care for you will not have to guess. Write your answers on page E6.

請思考如何令您活得有意義。
Think about what makes your life worth living.

❑ **只有當我還能做以下這些事項的時候，才值得活下去：**
My life is only worth living if I can:

在英文第六頁(E6)，您所同意的全部句子旁勾上X。
Put an X next to all the sentences you agree with on page E6.

- ❍ 能與家人或朋友交談 talk to family or friends
- ❍ 能從昏迷中甦醒 wake up from a coma
- ❍ 可以自己進食、洗澡或照顧自己 feed, bathe, or take care of myself
- ❍ 沒有痛楚 be free from pain
- ❍ 不需依賴機器維生 live without being hooked up to machines
- ❍ 我不確定 I am not sure

或 or

❑ **無論我病得多嚴重，都值得讓我活下去。**
My life is always worth living no matter how sick I am.

臨終時，我一定要：
If I am dying, it is important for me to be:

❑ 在家裡 at home ❑ 在醫院 in the hospital ❑ 我不確定 I am not sure

宗教或靈性需求對您很重要嗎？
Is religion or spirituality important to you?

❑ 不重要 no ❑ 很重要 yes 如果您有宗教信仰，您的宗教信仰是甚麼？
If you have one, what is your religion? _____

醫生應該知道有關我宗教或信仰的事宜：
What should your doctors know about your religion or spirituality?

_____

_____

當您生病時，醫生和護士一定會盡力讓您舒服，減除痛楚。
If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

請翻到下頁
Go to the next page

維持生命治療是要試著維持您的生命。包括運用心肺復甦術 (CPR) 、呼吸器、餵食管、洗腎、輸血或用藥等方式。

Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

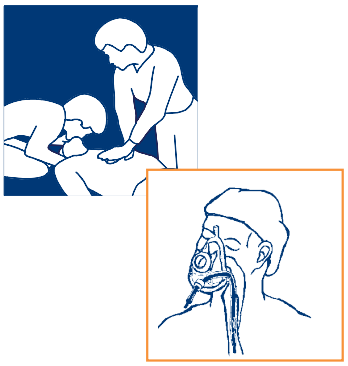
請您在最同意的一項選擇旁勾上X。 Put an X next to the one choice you most agree with.

請先把整頁的內容都讀完，再作出您的一項選擇。 Please read this whole page before you make your choice.

請在英文第七頁(E7)上作出您的選擇。 Mark your answers on page E7.

如果我病危，可能要離世：

If I am so sick that I may die soon:



☐ 請用醫生認為可能有幫助的『全部』維持生命治療方法。
Try all life support treatments that my doctors think might help.

如果治療**沒有效果**而且病情好轉的機會微小，
If the treatments **do not work** and there is little hope of getting better,

我仍然想要依賴維持生命的機器。
I want to stay on life support machines.

或 or

☐ 請用醫生認為可能有幫助的『全部』維生治療方法。
Try all life support treatments that my doctors think might help.

如果治療**沒有效果**而且病情好轉的機會微小，**我不想**依賴維持生命的機器。
If the treatments **do not work** and there is little hope of getting better, **I do not want to stay** on life support machines.

或 or

☐ 我希望醫生使用可能有幫助的所有維持生命治療方法。
Try all life support treatments that my doctors think might help **but not** these treatments.

請勾選您**不要**的治療項目。
Mark what you do not want.

- ○ 心肺復甦術 CPR
- ○ 血液透析術（洗腎） dialysis
- ○ 呼吸輔助器 breathing machine
- ○ 餵食管 feeding tube
- ○ 輸血 blood transfusion
- ○ 藥物 medicine
- ○ 其它治療方法 _____
  other treatments

或 or

☐ 我**不要使用任何**維持生命治療法。 **I do not want any** life support treatments.

或 or

☐ 我希望由我的**醫療代理人**幫我決定。 I want my **health care agent** to decide for me.

或 or

☐ 我不確定。 I am not sure.

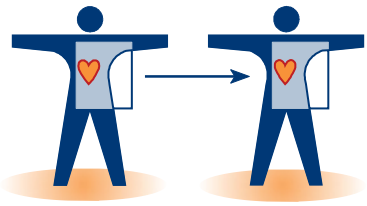
請翻到下頁
Go to the next page

醫生會問您是否願意在去世後捐贈器官和解剖遺體。 Your doctors may ask about organ donation and autopsy after you die.
請告訴我們您的意願。 Please tell us your wishes.

請在您最同意的一項選擇旁勾上 X。 Put an X next to the one choice you most agree with.
請在英文第八頁(E8)上作出您的選擇。 Mark your answers on page E8.

捐贈器官可以救活別人。

Donating (giving) your organs can help save lives.



- ☐ 我**願意**捐贈我的器官。
  I **want** to donate my organs.
  我想捐贈的器官是：
  Which organs do you want to donate?
  - ○ 任何器官 any organ
  - ○ 只捐贈 only _____
- ☐ 我**不願意**捐贈我的器官。
  I **do not** want to donate my organs.
- ☐ 我希望由我的**醫療代理人**幫我決定。
  I want my **health care agent** to decide.
- ☐ 我不確定。
  I am not sure.

解剖遺體可以確定死因。 An autopsy can be done after death to find out why someone died.

用外科手術解剖，可能需要幾天時間。 It is done by surgery. It can take a few days.

- ☐ 我**願意**解剖遺體。
  I **want** an autopsy.
- ☐ 我**不願意**解剖遺體。
  I **do not want** an autopsy.
- ☐ 如果我的死因有疑問時，我希望解剖遺體。
  I **want** an autopsy if there are questions about my death.
- ☐ 我希望由我的**醫療代理人**幫我決定。
  I want my **health care agent** to decide.
- ☐ 我不確定。
  I am not sure.

有關遺體的處理，您希望醫生注意什麼事項？

What should your doctors know about how you want your body to be treated after you die?

_____

_____

請翻到下頁在第三部份簽名
Go to Part 3 on the next page to sign this form

第三部份 在指示書英文第九頁(E9)上簽名

PART 3 Sign the form on page E9

要指示書生效，您必須： Before this form can be used, you must:

- 在指示書英文第九頁(E9)上簽名。 Sign the form on pae E9.
- 請兩位見證人在英文的第10頁上(E10)簽名。 Have two witnesses sign on page E10.

如果沒有見證人，您必須要有一位公證人在英文的第11頁(E11)簽名。 If you do not have witnesses, a notary public must sign on page E11.

公證人的職責是確定指示書由你本人簽署。 A notary public's job is to make sure it is you signing the form.

請在英文第九頁(E9)上簽名並註明簽署日期。 Sign your name and write the date on page E9.

簽名 (sign your name) _____ 日期 (date) ____/____/____

名字（正楷書寫名字）(print your first name) _____ 姓氏（正楷書寫姓氏）(print your last name) _____

地址 (address) _____ 城市 (city) _____ 州 (state) _____ 郵區號碼 (zip code) _____

您的見證人必須： Your witnesses must:

- 年滿 18 歲 be over 18 years of age
- 認識您 know you
- 親眼看到您在指示書上簽名 see you sign this form

見證人不可以： Your witnesses cannot:

- 是您的醫療代理人 be your health care agent
- 是您的醫護人員 be your health care provider
- 在您接受醫療服務的單位內工作 work for your health care provider
- 在您居住的地方工作(如果您住在療養院，請翻到英文第12頁(E12)) work at the place that you live (if you live in a nursing home go to page E12)

而且，一位見證人不能： Also, one witness cannot:

- 與您有任何親屬關係 be related to you in any way
- 在您去世後得到財政上的利益(得到金錢或財產) benefit financially (get any money or property) after you die

見證人必須在英文第十頁(E10)上簽名。

Witnesses need to sign their names on page E10.

如果您沒有見證人，請帶著本指示書由公證人在英文的第11頁(E11)上簽名。

If you do not have witnesses, take this form to a notary public and have them sign on page E11.

請您的見證人在英文第十頁(E10)上簽名和填寫今天的日期

Have your witnesses sign their names and write the date on page E10

透過簽名，本人證明 _____ 在本人面前親自在本指示書上簽名。
(名字)

By signing, I promise that _____ signed this form while I watched.
(name)

他（她）當時能清楚地思考，而且並未被迫簽名。

He/she was thinking clearly and was not forced to sign it.

本人也證明：I also promise that:

- 我認識他 (她)，或他 (她) 可證明自己是誰 I know him/her or this person could prove who he/she was
- 我已年滿 18 歲 I am 18 years or older
- 我不是他 (她) 的醫療代理人 I am not his/her health care agent
- 我不是他(她) 的醫療人員 I am not his/her health care provider
- 我不是替他(她) 的醫療人員工作 I do not work for his/her health care provider
- 我沒有在他 (她) 居住的地方工作 I do not work where he/she lives

有一位見證人也必須保證： One witness must also promise that:

- 我和他 (她) 沒有任何血緣、姻親或收養關係 I am not related to him/her by blood, marriage, or adoption
- 我不會在他（她）去世後得到財政上的利益(得到金錢或財產) I will not benefit financially (get any money or property) after he/she dies

第一位見證人：請在英文第十頁(E10)上簽名。 Witness #1: Sign on page E10.

簽名 (sign your name) _____ 日期 (date) ___/___/___

證人名字 (正楷書寫名字) (print your first name) _____ 姓氏（正楷書寫姓氏）(print your last name) _____

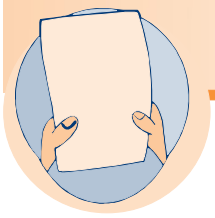
地址 (address) _____ 城市 (city) _____ 州 (state) _____ 郵區號碼 (zip code) _____

第二位見證人：請在英文第十頁(E10)上簽名。 Witness #2: Sign on page E10.

簽名 (sign your name) _____ 日期 (date) ___/___/___

證人名字 (正楷書寫名字) (print your first name) _____ 姓氏（正楷書寫姓氏）(print your last name) _____

地址 (address) _____ 城市 (city) _____ 州 (state) _____ 郵區號碼 (zip code) _____



您已經填妥指示書。 You are now done with this form.

請把這份指示書拿給您的醫生、護士、社工人員、朋友、家人和醫療代理人。

Share this form with your doctors, nurses, social workers, friends, family, and health care agent.

與他們談論您的選擇。

Talk with them about your choices.

公證人 Notary Public

- 如果找不到兩位見證人簽署指示書，
  才需要帶指示書請公證人為您做證。
  Take this form to a notary public only if two witnesses have not signed this form.

- 記得要帶有照片的證件（駕駛執照，護照等）
  Bring photo I.D. (driver's license, passport, etc.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California
County of _____

On _____ (Date) before me, _____ (Here insert name and title of the officer), personally appeared _____ (Name(s) of Signer(s))
_____,
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.

Signature _____ (Signature of Notary Public)

Description of Attached Document
Title or Type of document: _____
Date: _____ Number of pages: _____
Capacity(ies) Claimed by Signer(s)
Signer's Name: _____
☐ Individual
☐ Guardian or conservator
☐ Other _____

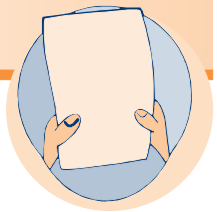
RIGHT THUMBPRINT OF SIGNER
Top of thumb here

(Notary Seal)

您已經填妥指示書。 You are now done with this form.

請把這份指示書拿給您的醫生、護士、社工人員、朋友、家人和醫療代理人。
Share this form with your doctors, nurses, social workers, friends, family, and health care agent.

與他們談論您的選擇。
Talk with them about your choices.



僅限居住在加州療養院的人填寫

For California Nursing Home Residents ONLY

- **若您住在療養院，請將本指示書交給療養院的主管。**
  Give this form to your nursing home director **only** if you live in a nursing home.

- **加州法律規定，如事前指示書的填寫人為居住在療養院的人，指示書的證人之一必須是療養院監察員（ombudsman）。**
  California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

病人權益代言人或監察員聲明

STATEMENT OF THE PATIENT ADVOCATE OR OMBUDSMAN

「本人聲明我是加州耆英署 (STATE DEPARTMENT OF AGING)

指派之病人權益代言人或監察員，根據遺囑認證法 (PROBATE CODE)

第 4675 條規定擔任本指示書證人，如有虛假，願受偽證罪處置。」

"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."

簽名 (sign your name) _____ 日期 (date) ___/___/___

證人名字 (正楷書寫名字) (print your first name) _____ 姓氏 (正楷書寫姓氏) (print your last name) _____

地址 (address) _____ 城市 (city) _____ 州 (state) _____ 郵區號碼 (zip code) _____

中文修訂:美華慈心關懷聯盟 網址: www.caccc-usa.org
Chinese modification by the Chinese America California Coalition for Compassionate Care: www.caccc-usa.org