ADVANCE HEALTH CARE DIRECTIVE

OF _____ *(Name)*

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 the designation of a primary practitioner or a primary physician in case you seek medical assistance such as the setting of a broken bone. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

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

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

a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
b) Select or discharge health care providers and institutions.
c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
e) Direct disposition of your remains and make anatomical gifts.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. This is where you can 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 write out any specific wishes you may have about your health care. If you wish to rely exclusively on Christian Science treatment for your care, you need not fill in the blank lined portion of Part 2 of this form.

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

Part 4 requests that no autopsy be performed on your remains. However, the final decision lies with the County Coroner.

Part 5 of this form lets you designate a practitioner or a physician to have primary responsibility for your health care.

Part 6 of this form relieves your agent from liability for choosing Christian Science treatment for you.

After completing this form, sign and date the form at the end. 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 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.

PART 1 - POWER OF ATTORNEY FOR HEALTH CARE

1.1 DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me: ***(Fill in name address and telephone number)***

Name: _____

Address: _____

Telephone Number: _____

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 the following individual as my first alternate agent:
(Fill in name address and telephone number)

Name: _____

Address: _____

Telephone Number: _____

OPTIONAL: If neither my agent nor my first alternate agent is willing, able, or reasonably available to make a health care decision for me, I designate the following individual as my second alternate agent:
(Fill in name address and telephone number)

Name: _____

Address: _____

Telephone Number: _____

1.2 AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me as long as he or she acts in accordance with the tenets and practices of Christian Science, 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:

_____

_____

1.3 WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: ***(Check one box)***

☐ My agent's authority to make health care decisions for me takes effect immediately. However, if I disagree with any of my agent's decisions about my health care, I may revoke his or her authority to make decisions for me. My named agent should be considered to be "currently acting" as a personal representative under HIPAA and thereby authorized to receive protected medical information under HIPAA whether or not I have been deemed incapacitated; ***OR***

☐ My agent's authority becomes effective when my Christian Science practitioner, my primary physician or two individuals who personally know me and are not employees/operators/owners of a care facility (unless they are related to me by blood or marriage or are my co-workers) determines that I am unable to make my own health care decisions.

1.4 AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent know 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 know to my agent.

1.5 AGENT'S POST DEATH AUTHORITY: My agent is authorized to direct the disposition of my remains, except as I state here:

_____

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

PART 2 - INSTRUCTIONS FOR HEALTH CARE

2.1 I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment as follows:

It is my desire to rely entirely and exclusively upon Christian Science treatment for all my health care needs. This treatment may include assistance by a Christian Science practitioner or Christian Science nurse. Other than as stated above, I do not wish to receive any medical life-prolonging care, treatment, services, medications, or procedures of a medical nature.

I authorize and direct my agent to arrange for my health care by spiritual means through prayer, exclusively. I desire to receive such Christian Science treatment at home, from a Christian Science practitioner. If any nursing care is deemed to be necessary, I prefer to receive it from a Christian Science nurse. Should I require nursing care outside the home, I prefer that my agent arrange for such care at an accredited Christian Science nursing facility. I do not wish to be hospitalized or placed in any convalescent or other facility which does not subscribe exclusively to the tenets and practices of Christian Science.

I request that no governmental agency nor any other group or individual intervene to cause medical treatment to be given to me or to cause me to be hospitalized against my stated wishes or against the instructions and decisions of my agent. By arranging for Christian Science treatment for me in lieu of medical treatment, even in a situation that may be deemed life threatening, my agent shall not be subject to civil or criminal liability.

Additionally, I direct that:

_____

_____

All references to Christian Science practitioner and Christian Science nurse shall mean those listed in the then-current edition of the *Christian Science Journal* or nurses affiliated and recommended by a Christian Science facility. All references to an accredited Christian Science nursing facility shall mean a Christian Science sanatorium or nursing facility accredited by either the Commission of Accreditation of Christian Science Nursing Organizations/Facilities, Inc. or the Organization for Accreditation of Christian Science Care Facilities. If the agent is unable to gain admission for me in a fully accredited Christian Science sanatorium or nursing facility, my agent is authorized to use a non-accredited Christian Science sanatorium or nursing facility provided such sanatorium or nursing facility requires patients to be under the care of a Christian Science practitioner.

PART 3 - DONATION OF ORGANS AT DEATH (OPTIONAL)

3.1 ***(Check one box)***

- ☐ a) Upon my death I do not wish to donate any organs
- ☐ b) Upon my death I give any needed organs, tissues, or parts
- ☐ c) Upon my death I give the following organs, tissues, or parts only:

_____

My gift is for the following purposes: ***(Strike out any of the following that you do not want)***

Transplant Therapy Research Education

PART 4 - RELIGIOUS OBJECTION TO AUTOPSY

4.1 Based on my religious beliefs, I object to any and all post-mortem anatomical dissections or other autopsy procedures being conducted on my body since it would violate my religious convictions. I therefore request that no autopsy be performed on my remains.

PART 5 - PRIMARY PRACTITIONER / PHYSICIAN (OPTIONAL)

5.1 I designate the following Christian Science practitioner or physician as my primary practitioner or my primary physician: ***(Fill in name address and telephone number)***

Name: _____

Address: _____

Telephone Number: _____

PART 6 - WAIVER OF LIABILITY FOR CHRISTIAN SCIENCE TREATMENT

6.1 I understand that this Advance Health Care Directive gives my agent the authority to direct my care only in accordance with the tenets and practices of Christian Science, unless I have specifically stated to the contrary in this Directive. I hereby agree to hold harmless and to waive any liability on the part of my agent, any Christian Science practitioner, and any Christian Science facility for harm or injury that I may suffer after complying with my instructions in this Directive about receiving care only in accordance with the tenets and practices of Christian Science. I further state that this Waiver of Liability is to be binding on my heirs, successors and assigns.

6.2 If my health care provider refuses to honor my agent's decisions, I empower my agent to direct my health care provider to transfer my care to another health care provider who will honor my instructions. If my health care provider thwarts, undermines, or does not honor to the fullest extent my instructions or my agent's decisions, I further direct and empower my agent to initiate an action for battery against my health care provider.

PART 7 - CONCLUSION

7.1 **EFFECT OF COPY:** A copy of this form has the same effect as the original.

7.2 **REVOCATION OF PRIOR DOCUMENTS:** By signing below, I revoke any prior durable powers of attorney for health care or any prior advance health care directives.

7.3 **SIGNATURE:** ***(Sign and date the form here)***

Date: _____ **Signature:** _____

Print or Type Name: _____

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 _____)

COUNTY OF _____)

On _____ before me, _____
Date *Notary*

personally appeared _____
Name of signer

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.

Place Notary Seal below:

_____
Signature of Notary Public

My commission expires: _____