Advance Health Care Directive Patient Information

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.

An Advance Health Care Directive lets you do one or both of these things. It also lets you write down your wishes about donation of organs. You have the right to change or revoke your Advance Health Care Directive at any time. If you use the form provided, you may complete or change any part of it or all of it. You are free to use a different form.

Power of Attorney

A Power of Attorney lets you name another person as **agent** to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions. You may **also name** an **alternate agent** to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

Your **agent** may not be:

- an operator or employee of a community care facility or a residential care facility where you are receiving care.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Instructions for Health Care

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.

Donation of Organs

You can write down your wishes about donating your bodily organs and tissues following your death.

Primary Physician

You can select a physician to have primary or main responsibility for your health care.

Signature and Witnesses

After completing an Advance Health Care Directive you must **sign and date it.** The form provided must be signed **by two qualified witnesses or** acknowledged before a notary public. A Patient Advocate or Ombudsman must witness the form ***if you are a patient in a skilled nursing facility.***

The Women's Plastic Surgery respects and upholds the rights of all patients to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on their expressed wishes when they are unable to make decisions or unable to communicate decisions.

WOMEN'S PLASTIC SURGERY

ADVANCE HEALTH CARE DIRECTIVE

All patients have the right to participate in their own health care decision and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. The Women's Plastic Surgery respects and upholds those rights. At Women's Plastic Surgery the Medical Staff have the primary responsibility for discussing Advance Directive with patients. The Medical Staff's responsibility is to provide information and education to enable individuals to make decisions regarding their Advance Directive in a thoughtful and informed manner. You should have the opportunity to review information regarding Advance Directive prior to the scheduled date of the surgery.

Have you executed an Advance Health Care Directive, a Living Will, a Power of Attorney that authorizes someone to make health care decisions for you? *Please check the appropriate box*

- ☐ I have an Advance Directive, Living Will or Health Care Power of Attorney
- ☐ I have an Advance Directive, Living Will or Health Care Power of Attorney, but I have no copy with me.
- ☐ I did not chose to execute an Advance Directive, Living Will or Health Care Power of Attorney

If you checked the first box above, please provide us a copy of that document so that it may be made a part of your medical record.

PATIENT CONSENT TO RESUSCITATIVE MEASURES

Not a Revocation of Advance Directives Or Medical Powers of Attorney

Unlike in an Acute Care Hospital setting, the Women's Plastic Surgery does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an Acute Care Hospital for further evaluation. At the Acute Care Hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive or Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Health Care directive or Health Care Power of Attorney.

If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described and I have had the opportunity to review information and prepare an Advance Health Care Directive.

By:_____ Date:_____
(Patient's Signature)

If consent to the procedure is provided by anyone other than the patient, this form must be signed by the person providing the consent or authorization.

I acknowledge that I have read and understand its contents and agree to the policy as described.
By:_____
(Signature)

_____
(Print Name)

Relationship to Patient
- ☐ Court Appointed Guardian
- ☐ Attorney in Fact
- ☐ Health Care Surrogate
- ☐ Other

FORM 3-1

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS

Part 1 of this form lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you.

Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless you state otherwise in this form, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
2. Select or discharge health care providers and institutions.
3. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
4. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
5. Donate organs or tissues, authorize an autopsy, and direct disposition of remains.

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

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You also can add to the choices you have made or write down 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.

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

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

Name of individual you choose as agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

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

Name of individual you choose as first alternate agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

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

Name of individual you choose as second alternate agent: _____

Address: _____

_____

Telephone: _____
(home phone) *(work phone)* *(cell/pager)*

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.)

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. _____
(Initial here)

OR

My agent's authority to make health care decisions for me takes effect immediately. _____
(Initial here)

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.

AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

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.

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:

Choice *Not To* Prolong Life:

_____ *(Initial here)* 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

Choice *To* Prolong Life:

_____ *(Initial here)* I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

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

_____

_____

(Add additional sheets if needed.)

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)

I. Upon my death:

I give any needed organs, tissues, or parts _____
(Initial here)

OR

I give the following organs, tissues, or parts only: _____ _____
(Initial here)

II. If you wish to donate organs, tissues, or parts, you must complete II and III.

My gift is for the following purposes:

Transplant _____ *(Initial here)*

Research _____ *(Initial here)*

Therapy _____ *(Initial here)*

Education _____ *(Initial here)*

III. I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

1. My donated skin may be used for cosmetic surgery purposes.

   Yes _____ *(Initial here)*

   No _____ *(Initial here)*

2. My donated tissue may be used for applications outside of the United States.

   Yes _____ *(Initial here)*

   No _____ *(Initial here)*

3. My donated tissue may be used by for-profit tissue processors and distributors:

Yes_____ No _____
(Initial here) *(Initial here)*

(Health and Safety Code Section 7158.3)

PART 4 – PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name of Physician: _____ Telephone: _____

Address: _____

_____

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: _____ Telephone: _____

Address: _____

_____

PART 5 – SIGNATURE

The form must be signed by you and by two qualified witnesses, or acknowledged before a notary public.

SIGNATURE: Sign and date the form here:

Date: _____

Name: _____ _____
(sign your name) *(print your name)*

Address: _____

_____

STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, 3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility,

the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

FIRST WITNESS

Name: _____ Telephone: _____

Address: _____

_____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Name: _____ Telephone: _____

Address: _____

_____

Signature of Witness: _____ Date: _____

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

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

Signature of Witness: _____

YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC INSTEAD OF THE STATEMENT OF WITNESSES.

State of California)
)
)

County of _____

On *(date)* _____ before me, *(here insert name and title of the officer)* _____

_____

personally appeared *(name(s) of signer(s))* _____,

personally known to me (or 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.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature of Notary: _____ (Seal)

PART 6—SPECIAL WITNESS REQUIREMENT

If you are a patient in a skilled nursing facility, the patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Date: _____

Name: _____ _____
(sign your name) *(print your name)*

Address: _____

_____

FORM 3-1S

DIRECTIVA POR ANTICIPADO DE LA ATENCIÓN DE LA SALUD

INSTRUCCIONES

La Sección 1 de este formulario le permite nombrar a otro individuo como representante para que tome las decisiones de atención de la salud por usted en caso que llegue a ser incapaz de tomar sus propias decisiones o si usted quiere que alguien más tome esas decisiones por usted ahora aunque todavía siga siendo capaz. También puede nombrar a un representante suplente que actúe por usted si su primera elección no está dispuesta, no es capaz o no está razonablemente accesible para tomar decisiones por usted.

Su representante no puede ser un operador o empleado de un establecimiento de atención comunitaria y un establecimiento de atención residencial donde lo estén atendiendo, ni su proveedor de atención de la salud encargado de la supervisión o un empleado de la institución de atención de la salud donde usted esté recibiendo la misma, a menos que su representante esté emparentado con usted o sea compañero de trabajo.

A menos que indique lo contrario en este formulario, su representante tendrá el derecho de:

1. Prestar o negar el consentimiento a cualquier atención, tratamiento, servicio o procedimiento para mantener, diagnosticar o afectar de otro modo una enfermedad física o mental.
2. Seleccionar o rechazar proveedores e instituciones de atención de la salud.
3. Aprobar o desaprobar pruebas diagnósticas, procedimientos quirúrgicos y programas de medicamentos.
4. Dirigir el proveimiento, la negación o la retirada de nutrición e hidratación artificial y todas las demás formas de atención de la salud, incluyendo resucitación cardiopulmonar.
5. Donar órganos o tejidos, autorizar una autopsia y ordenar la disposición final de los restos.

Sin embargo, su representante no podrá internarlo en un establecimiento psiquiátrico ni dar su consentimiento para que usted sea sometido a tratamiento convulsivo, psicocirugía, esterilización o aborto.

La Sección 2 de este formulario le permite dar instrucciones específicas acerca de cualquier aspecto de su atención de la salud, ya sea que usted nombre un representante o no. Se proporcionan opciones para que usted exprese sus deseos acerca del proveimiento, la negación o la retirada del tratamiento para mantenerlo vivo, así como el proveimiento de alivio del dolor. También se proporciona espacio para que usted aumente las opciones que haya hecho o que anote cualesquier deseos adicionales. Si está conforme con dejar que su representante determine lo que sea mejor para usted al tomar decisiones relacionadas con el final de la vida, no es necesario que llene la Parte 2 de este formulario.

Entrégueles copias del formulario firmado y debidamente llenado a su médico, a cualesquier otros proveedores de atención de la salud que pueda tener, a cualquier institución de atención de la salud en la que lo estén atendiendo y a todos los representantes de atención de la salud que haya nombrado. Deberá hablar con la persona que haya nombrado como representante para asegurar que él o ella entienda sus deseos y esté dispuesta a asumir la responsabilidad.

Usted tiene derecho a revocar esta directiva por anticipado de la atención de la salud o a reemplazar este formulario en cualquier momento.

PARTE 1 – PODER NOTARIAL PARA ATENCIÓN DE LA SALUD

DESIGNACIÓN DEL REPRESENTANTE: Designo al siguiente individuo como mi representante para que tome las decisiones de atención de la salud por mí:

Nombre del individuo que usted elija como representante _____

Dirección: _____

_____

Teléfono: _____
(en casa) *(teléfono en el trabajo)* *teléfono celular / localizador*

OPCIONAL: Si revoco la autoridad de mi representante o si mi representante no está dispuesto, no es capaz o no está razonablemente accesible para tomar una decisión de atención de la salud por mí, designo como mi primer representante suplente a:

Nombre de la persona que usted elige como primera alternativa: _____

Dirección: _____

_____

Teléfono: _____
(en casa) *(teléfono en el trabajo)* *teléfono celular / localizador*

OPCIONAL: Si revoco la autoridad de mi representante y mi primer representante suplente o si ninguno de los dos está dispuesto, es capaz o está razonablemente accesible para tomar una decisión de atención de la salud por mí, designo como mi segundo representante suplente a:

Nombre del individuo que usted elija como su segundo representante suplente _____

Dirección: _____

_____

Teléfono: _____
(en casa) *(teléfono en el trabajo)* *teléfono celular / localizador*

AUTORIDAD DEL REPRESENTANTE: Mi representante está autorizado para tomar todas las decisiones de atención de la salud por mí, incluyendo las decisiones para proveer, negar o retirar la nutrición e hidratación artificial y todas las demás formas de atención de la salud para mantenerme vivo, excepto como lo consigno aquí:

_____

_____

_____

(Si es necesario, agregue hojas adicionales.)

CUÁNDO ENTRA EN VIGENCIA LA AUTORIDAD DEL REPRESENTANTE: La autoridad de mi representante entra en vigencia cuando mi médico de atención primaria determine que soy incapaz de tomar mis propias decisiones de atención de la salud. _____

(Escriba sus iniciales aquí)

La autoridad de mi representante para tomar las decisiones de atención de la salud por mí entra en vigor inmediatamente. _____

(Escriba sus iniciales aqu)

OBLIGACIÓN DEL REPRESENTANTE: Mi representante tomará decisiones de atención de la salud por mí de acuerdo con este poder notarial para atención de la salud, todas las instrucciones que yo proporcione en la Parte 2 de este formulario y mis demás deseos en la medida conocida para mi representante. En la medida que mis deseos sean desconocidos, mi representante tomará decisiones de atención de la salud por mí de acuerdo con lo que mi representante determine que es en mi mejor interés. Para determinar mi mejor interés, mi representante deberá considerar mis valores personales en la medida conocida por el mismo.

AUTORIDAD DEL REPRESENTANTE DESPUÉS DE LA MUERTE: Mi representante está autorizado para hacer donaciones anatómicas, autorizar una autopsia y ordenar la disposición final de mis restos, excepto como yo lo consigno aquí o en la Parte 3 de este formulario:

_____

_____

_____

(Si es necesario, agregue hojas adicionales.)

NOMBRAMIENTO DE CURADOR: Si algún tribunal necesita nombrar a un curador de mi persona, propongo al representante designado en este formulario. Si dicho representante no está dispuesto, no es capaz o no está razonablemente disponible para actuar como curador, propongo a los representantes suplentes que he nombrado, en el orden designado.

PARTE 2 – INSTRUCCIONES PARA LA ATENCIÓN DE LA SALUD

Si usted llena esta parte del formulario, podrá tachar cualquier texto que no quiera.

DECISIONES DEL FINAL DE LA VIDA: Ordeno que mis proveedores de atención de la salud y otros que participen en mi atención provean, nieguen o retiren el tratamiento de acuerdo con la elección que yo haya marcado abajo:

Elección de no prolongar la vida

_____ *(Inicial aquí)* No quiero que mi vida sea prolongada si (1) tengo una enfermedad incurable e irreversible que resulte en mi muerte dentro de un periodo relativamente corto, (2) pierdo el conocimiento y, con un grado razonable de certidumbre médica, no lo recuperaré o (3) los riesgos y cargas probables del tratamiento serían más mayores que los beneficios previstos,

O

Elección de prolongar la vida

_____ *(Inicial aquí)* Quiero que mi vida sea prolongada tanto como sea posible dentro de los límites de las normas de atención de la salud generalmente aceptadas.

ALIVIO DEL DOLOR: Excepto como lo consigno en el siguiente espacio, ordeno que se me proporcione en todo momento tratamiento para el alivio del dolor o las molestias, aunque acelere mi muerte:

(Si es necesario, agregue hojas adicionales).

OTROS DESEOS: (Si usted no está de acuerdo con alguna de las elecciones opcionales que aparecen arriba y desea anotar las suyas propias, o si desea aumentar las instrucciones que ha proporcionado arriba, puede hacerlo aquí). Ordeno que:

_____

_____

_____

_____

(Si es necesario, agregue hojas adicionales.)

PARTE 3 – DONACIÓN DE ÓRGANOS DESPUÉS DE LA MUERTE (OPCIONAL)

I. Después de mi muerte

Dono todos los órganos, tejidos o partes necesarios, _____
(Escriba sus iniciales aquí)

O

Dono solamente los siguientes órganos, tejidos o partes. _____
(Escriba sus iniciales aquí)

II. Si usted desea donar a órganos, tejidos o partes, usted debe completar II y III

Mi donación es para los siguientes propósitos (tache cualquiera de los siguientes que usted no desee):

Trasplante _____ *(Escriba sus iniciales aquí)*

Investigación _____ *(Escriba sus iniciales aquí)*

Terapia _____ *(Escriba sus iniciales aquí)*

Educación _____ *(Escriba sus iniciales aquí)*

III. Entiendo que los bancos de tejidos trabajan con procesadores y distribuidores de tejidos tanto con fines de lucro como sin fines de lucro. Es posible que la donación de piel se use para fines cosméticos o de cirugía reconstructiva. Es posible que la donación de tejido se use para trasplantes fuera de los Estados Unidos.

1. Mi donación de piel puede usarse con fines de cirugía cosmética.

   Sí _____ *(Inicial aquí)*

   No _____ *(Inicial aquí)*

2. Mi donación de tejido puede usarse para aplicaciones fuera de los Estados Unidos.

   Sí _____ *(Inicial aquí)*

   No _____ *(Inicial aquí)*

3. Mi donación de tejido puede ser usada por procesadores y distribuidores de tejidos con fines lucrativos:

Sí _____ *(Inicial aquí)*

No _____ *(Inicial aquí)*

(Código de Salud y Seguridad, Sección 7158.3)

PARTE 4 – MEDICO DE ATENCIÓN PRIMARIA (OPCIONAL)

Designo al siguiente como mi médico de atención primaria:

Nombre del Médico: _____ Teléfono: _____

Dirección: _____

_____

OPCIONAL: Si el médico que he designado no está dispuesto, no es capaz o no está razonablemente accesible para actuar como mi médico de atención primaria, designo al siguiente para que desempeñe este papel:

Nombre del Médico: _____ Teléfono: _____

Dirección: _____

_____

PARTE 5 – FIRMA

El formulario debe ser firmado por usted y dos testigos calificados o certificado ante un notario público.

FIRMA: Firme y ponga aquí la fecha en el formulario:

Fecha: _____

Nombre: _____ _____
(ponga su firma) *(escriba su nombre con letra de molde)*

Dirección: _____

_____

DECLARACIÓN DE LOS TESTIGOS: Declaro bajo pena de perjurio conforme a las leyes de California (1) que el individuo que firmó o certificó esta directiva por anticipado de la atención de la salud es conocido personalmente para mí, o que la identidad del individuo me fue demostrada con evidencia convincente, (2) que el individuo firmó o certificó esta directiva por anticipado en mi presencia, (3) que el individuo parece encontrarse en buen estado mental y bajo ninguna presión, fraude o influencia indebida, (4) que no soy la persona designada como representante en esta directiva por anticipado y (5) que no soy el proveedor de atención de la salud del individuo,

un empleado del proveedor de atención de la salud del individuo, el operador de un establecimiento de atención comunitaria, un empleado de un operador de un establecimiento de atención comunitaria, el operador de un establecimiento de atención residencial para ancianos, ni un empleado de un operador de un establecimiento de atención residencial para personas de edad avanzada.

Nombre: _____ Teléfono: _____

Dirección: _____

_____

Firma del testigo: _____ Fecha: _____

SEGUNDO TESTIGO

Nombre: _____ Teléfono: _____

Dirección: _____

_____

Firma del testigo: _____ Fecha: _____

DECLARACIÓN ADICIONAL DE LOS TESTIGOS: Por lo menos uno de los testigos mencionados arriba también debe firmar la siguiente declaración:

Declaro además bajo pena de perjurio conforme a las leyes de California que no estoy emparentado por lazos sanguíneos, matrimonio o adopción con el individuo que formaliza esta directiva por anticipado de la atención de la salud, y que a mi leal saber y entender, no tengo derecho a parte alguna del caudal hereditario del individuo después de su muerte bajo un testamento actualmente existente o por ministerio de ley.

Firma del testigo: _____

Usted puede usar este certificado de confirmación ante notario público en vez de la declaración de testigos.

State of California)
)
)

County of _____

On *(date)* _____ before me, *(here insert name and title of the officer)* _____
_____

personally appeared *(name(s) of signer(s))* _____,

personally known to me (or 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.

WITNESS my hand and official seal. [Civil Code Section 1189]

Signature of Notary: _____ (Seal)

PARTE 6 – REQUERIMIENTO DE TESTIGO ESPECIAL

Si usted es paciente en un establecimiento con servicio de enfermería especializada, el abogado o defensor cívico del paciente debe firmar la siguiente declaración:

DECLARACIÓN DEL ABOGADO O DEFENSOR CÍVICO DEL PACIENTE

Declaro bajo pena de perjurio conforme a las leyes de California que soy abogado o defensor cívico del paciente designado por el Departamento de la Senectud del Estado y que estoy sirviendo como testigo como lo estipula la Sección 4675 del Código Testamentario.

Fecha: _____

Nombre: _____ _____
(ponga su firma) *(escriba su nombre con letra de molde)*

Dirección: _____
_____