OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE

THIS FORM IS OPTIONAL. Each paragraph and word of this form is also optional. If you use this form, you may cross out, complete or modify all or any part of it. You are free to use a different form. If you use this form, be sure to sign it and date it.

INSTRUCTIONS

PART 1 of this form is a power of attorney for health care. PART 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a health-care institution at which you are receiving care.

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.

PART I
POWER OF ATTORNEY FOR HEALTH CARE

This part is the health-care power-of-attorney form, which allows you to name an individual to act as your agent to make health care decisions for you

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

_____

Name Phone Number

_____

Address City State Zip Code

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 Phone Number

_____

Address City State Zip Code

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 Phone Number

_____

Address City State Zip Code

If you give your agent unlimited authority, they will have the right to:
(a) consent or refuse 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, programs of medication and orders not to resuscitate; and
(d) direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me and to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician and one other qualified health-care professional determine that I am unable to make my own health-care decisions. **If I initial this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.**

(4) DURABILITY OF AGENT'S AUTHORITY: I intend for this Power of Attorney to be durable and to remain in full force and effect during any period of time where I have been determined to be incapacitated pursuant to Paragraph 3 above. Furthermore, I intend for this Power of Attorney to be effective notwithstanding any lapse of time since its execution. The durability of this Power of Attorney does not in any way affect my ability to revoke this instrument pursuant to Paragraph 14 below.

(5) AGENT'S OBLIGATIONS: 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.

(6) NOMINATION OF GUARDIAN: If a guardian 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 guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

PART 2 of this form lets you give specific instructions about any aspect of your health care.

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

(7) END OF LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN 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 initialed below in one of the following three boxes:

Choices are provided for you to express your wishes regarding life-sustaining treatment, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Initial and check each choice that you want your health care provider or agent to follow. In addition, you may express your wishes regarding whether you want to make an anatomical gift of some or all of your organs and tissue. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

[ ] (a) I CHOOSE NOT TO PROLONG LIFE
I do not want my life to be prolonged.

[ ] (b) I CHOOSE TO PROLONG LIFE
I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

[ ] (c) I CHOOSE TO LET MY AGENT DECIDE
My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

(8) ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above NOT to prolong life, I also specify by marking my initials below:

[ ] I DO **NOT** want artificial nutrition

OR

[ ] I DO WANT artificial nutrition.

[ ] I DO **NOT** want artificial hydration unless required for my comfort

OR

[ ] I DO WANT artificial hydration.

(9) RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible be provided at all times to keep me clean, comfortable and free of pain or discomfort so that my dignity is maintained, even if this care hastens my death.

(10) ANATOMICAL GIFT DESIGNATION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

[ ] I CHOOSE to make an anatomical gift of my organs or tissue to be determined by medical suitability at the time of death, or by my wishes listed below, and artificial support may be maintained long enough for organs to be removed. I wish to make ONLY the following donation: _____.

[ ] I REFUSE to make an anatomical gift of any of my organs or tissue.

[ ] I CHOOSE to let my agent decide.

(11) OTHER WISHES: (If you wish to write your own instructions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:_____

_____

_____

PART 3
PRIMARY PHYSICIAN

PART 3 of this form lets you designate a physician to have primary responsibility for your health care, makes a copy as effective as an original, and allows you to revoke at any time.

(12) PRIMARY PHYSICIAN: I designate the following physician as my primary physician: _____

(13) EFFECT OF COPY: A copy has the same effect as the original.

(14) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health-care provider and any health-care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or personally informing the supervising health-care provider.

SIGNATURE: Sign and date the form here:

_____

Your signature Address

_____ _____

Today's Date Print your name

(Optional) SIGNATURE OF WITNESSES:

First Witness **Second Witness**

_____

Name Address Name Address

_____

Signature of Witness Date Signature of Witness Date

(**Optional)** NOTARY PUBLIC

STATE OF NEW MEXICO)
)ss.
County of _____)

THE FOREGOING instrument was acknowledged before me this _____ day of _____, 20_____, by the principal, _____.

_____
NOTARY PUBLIC

(SEAL)

My Commission expires: _____ .