

## SAMPLE ADVANCE DIRECTIVES

An advance directive is a statement made by a competent person, directing his or her medical care, should he or she become incompetent. Two of the most common examples of advance directives include the living will and the durable power of attorney for health care.

The attached are examples of advance directives, as developed by the Arizona Hospital Association, but for more information about a living will or durable power of attorney for health care, other sources are listed below. If you do execute an advance directive, please provide a copy to be kept in your medical record.

Aging and Adult Administration  
State of Arizona  
1789 W. Jefferson Street  
Site Code 950A  
Phoenix, AZ 85007  
Ray De La Rosa  
(602) 542-6440

Area Agency on Aging  
Senior Help Line  
1366 E. Thomas  
Phoenix, AZ 85014  
(602) 264-4357

Dorothy Garske Center  
Your Health Care Choices Program  
4250 E. Camelback Road, Suite 185K  
Phoenix, AZ 85018  
(602) 952-1464

Choice In Dying  
200 Varik St.  
New York, NY 10014  
(212) 366-5540

*For assistance in writing an advance directive:*  
Arizona Senior Citizens Law Project  
1818 S. 16th Street Phoenix, AZ 85034  
(602) 252-6710

American Association of Retired Persons (AARP)  
601 E Street, NW  
Washington, DC 20049  
(202) 434-2277

Combined Form

I, \_\_\_\_\_, as principal, designate \_\_\_\_\_ as my agent for all matters relating to my health care, including, without limitation, full power to give or to refuse consent to all medical, surgical, hospital, psychiatric and related health care. This power of attorney is effective whenever I am unable to make or to communicate health care decisions. All of my agent's actions under this power have the same effects on my heirs, devisees, and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or to continue to serve, I hereby appoint \_\_\_\_\_ as my agent. In acting under this power, I want my agent to give great weight to the following statements: I am In favor of trial treatment. That means I want all necessary medical care to treat my condition until, and only until, my doctors and my agent reasonably decide that I am in an irreversible coma, or a persistent vegetative state, or a locked-in state, or that I cannot be expected to return to a fully conscious state. If, following the guidelines stated above, my doctors and my agent decide that further medical care is inappropriate:

- 1. I want only comfort care and I do not want to undergo artificial administration of food or fluids.
2. I do not want to be resuscitated In case I stop breathing or my heart stops beating.

If my doctors and my agent reasonably decide that I have a terminal illness, I want all decisions concerning my medical and surgical care to be made in light of the expected length and quality of life which would result from such care and the predictable effects on me of undergoing treatment. If I cannot be expected to have a significant period of conscious life even after medical or surgical care, then I want comfort care only.(Examples I do not want any surgery or other care designed to prolong my life. I do not want artificially administered food or fluids and I do not want to be resuscitated.) This combined health care directive is made under § 36-3221 and § 36-3261, Arizona Revised Statutes. It continues effect for all who may rely on it, except those to whom I have given notice of its revocation.

Other or Additional Statements of Desires

Dated \_\_\_\_\_ Signature or Mark of Person Making Living Will \_\_\_\_\_

Verification

I affirm that: (1) I was present when this living will was dated and signed or marked or (2) the person making this living will directly indicated to me that the living will expressed that person's wishes and that the person intended to adopt it at that time. The maker of this document appeared to be of sound mind and free from duress.

(If there is only one witness signing this document) I certify that: I have not been designated to make medical decisions for the person who signed this living will, I am not directly involved with providing health care to this person, I am not related to that person by blood, marriage, or adoption and I am not entitled to any part of the person's estate.

Witness \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

STATE OF ARIZONA )
) as.
County of )

The maker of this document appears to be of sound mind and free from duress. It was subscribed and sworn to before me this \_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_ My Commission Expires \_\_\_\_\_

Notary Public

(A health care power of attorney and living will must be signed by a notary or by an adult witness or witnesses, who saw you sign or mark the document and who say that you appear to be of sound mind and free from duress. A notary or witness cannot be the person you name to make your decisions or your provider of health care.)