



Instructions for Completing the Health Care Directive

1. Print your name on the first blank line. "I, MY NAME, want everyone who cares for me to know what health care I want when I cannot let others know what I want."
2. Think about the statement, "A quality of life that is unacceptable to me means" and check each item from the list below that applies.

This means that if you are in the condition described, you would want your family and doctors to stop or withdraw treatment. You would not want to continue to live in that condition.

You may add any words you want on the blank lines to further describe the conditions when you would not want to continue to receive treatment. You may cross out anything on this form that you do not want or do not agree with.

3. Think about the statement, "There are some procedures that I do not want under any circumstances."

If you have decided that you would never want a treatment listed, check that box. If you have not decided yet, or if you would want your doctor to try these treatments, leave the box blank.

4. Think about the statement, "When I am near death, it is important to me that." You can write anything you like on these lines. Some people say, "I want hospice care.", "I want to die at home.", or "I want my family near me." You may leave these lines blank if you wish.
5. You must sign this form on the reverse side and you must have your signature witnessed.

The witness cannot be related to you by blood, marriage or adoption, cannot be a beneficiary to your estate and cannot be directly involved in your healthcare.

In Arizona, it is not necessary to have this form notarized, but there is a space for a notary if your desire.

6. Give a copy of your Health Care Directive to your Health Care (Medical) Power of Attorney, to your family and close friends, and to your doctor. Keep a copy to take to the hospital or clinic if you become ill and need treatment.

Instructions for Completing the Health Care (Medical) Power of Attorney with Mental Health Authority

1. Print your name in the first blank line.

"I, MY NAME, as principal, designate . . . "

2. Print the name of the person you have chosen to be your Health Care (Medical) Power of Attorney on the next blank line.

"OTHER PERSON'S NAME, as my agent for all matters relating to my health care ..."

3. Print the address and phone number of the person you have chosen to be your Health Care (Medical) Power of Attorney on the next blank line.

"Print agent ADDRESS and PHONE"

4. You may name an alternate person to be your Health Care (Medical) Power of Attorney. This second person would take over if the first person you named is not available or is unable to make decisions for you.

"If my agent is unwilling or unable to serve or continue to serve, I hereby appoint SECOND PERSON'S NAME as my agent."

5. If you choose a second person as an alternate, complete the next blank line with the second person's address and phone number. If you do not choose a second person as an alternate, leave this last line blank.

6. You must sign this form in front of a witness.

The witness cannot be related to you by blood, marriage or adoption, cannot be a beneficiary to your estate and cannot be directly involved in your healthcare.

In Arizona, it is not necessary to have this form notarized, but there is a space for a notary. If you travel out of state with these documents, you may want to have your signature notarized.

7. Give a copy of this form to your Health Care (Medical) Power of Attorney, to your family and close friends, and to your doctor. Keep a copy to take to the hospital or clinic if you become ill and need treatment.