

# HEALTH CARE POWER OF ATTORNEY & LIVING WILL Combined Form

**General Instructions:** Use this Health Care Power of Attorney and Living Will Combined Form if you want to select a person to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Talk to your family, friends and others you trust about your choices. Also, it's a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you sign this form. Be sure you understand the importance of this document. If you decide this is the form you want to use, complete the form. **Do not sign this form** until your witness or a Notary Public is present to witness the signing.

<b>1. Information about me (I am called the "Principal"):</b>	
My Name: _____	My Age: _____
My Address: _____	My Date of Birth: _____
City, State, Zip: _____	Home Telephone: _____
	Work Telephone: _____
	Cell Phone: _____

<b>2. I designate the following person to serve as my Agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care including mental health care:</b>	
Name: _____	Home Telephone: _____
Street Address: _____	Work Telephone: _____
City, State, Zip: _____	Cell Telephone: _____
<b>3. I choose the following person to act as an Alternate Representative to make healthcare decisions for me if my first representative is unavailable, unwilling or unable to serve or continue to serve:</b>	
Name: _____	Home Telephone: _____
Street Address: _____	Work Telephone: _____
City, State, Zip: _____	Cell Telephone: _____

By initialing here, I consent to giving my Agent the power to admit me to an inpatient or partial psychiatric hospitalization program, including a level one behavioral health facility. Please initial here: \_\_\_\_\_ (INITIAL IF YOU CONSENT)

This Health Care Power of Attorney and Living Will Combined Form 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.

In acting under this power, I want my Agent to give great weight to the following statements:

(Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should **initial** that statement. **Read all of these statements carefully before you initial your section.** You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3, and 4, but if you initial paragraph 5 the others should **not** be initialed.)

1. \_\_\_\_\_ If I have a terminal condition I **do not want** my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care, that would serve **only** to artificially delay the moment of my death. (Note: "Comfort care" means treatment given in an attempt to protect and enhance the quality of life without artificially prolonging that life).
2. \_\_\_\_\_ If I am in a terminal condition or I am in an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable I **do want** the medical treatment necessary to provide care that would keep me comfortable, but I **do not** want the following:
  - \_\_\_\_\_ (a) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock, and artificial breathing.
  - \_\_\_\_\_ (b) Artificially administered food and fluids.
  - \_\_\_\_\_ (c) To be taken to a hospital if it is at all avoidable.
3. \_\_\_\_\_ Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.
4. \_\_\_\_\_ Notwithstanding my other directions, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.
5. \_\_\_\_\_ I want my life to be prolonged to the greatest extent possible.

**Other or Additional Statements of Desires**

I have \_\_\_\_\_ I have not \_\_\_\_\_ attached additional special provisions or limitations to this document to be honored in the absence of my being able to give healthcare directions.

This combined health care directive is made under [36-3221] and [36-3261], Arizona Revised Statutes. It continues in effect for all who may rely on it, except those to whom I have given notice of its revocation, or if it has been revoked by an order of a court.

**Principal's Signature or Verification**

I am signing this Healthcare Power of Attorney and Living Will Combined Form as follows:

Signature or Mark of Principal: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Signature of Witness or Notary Public**

Note: At least one adult witness OR a Notary Public must witness the signing of this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) Under the age of 18; (b) Related to you by blood, adoption or marriage; (c) Entitled to any part of your Estate; (d) Appointed as your representative; or (e) Involved in providing your healthcare at the time this document is signed.

1. **Witness Section** (Witness shall select one of the two boxes below, and sign and date the document as required).

- **Witness Certification:** I certify that I have witnessed the signing of this document by the Principal. The person who signed this Healthcare Power of Attorney and Living Will Combined Form appeared to be of sound mind and under no pressure to make specific choices or to sign the document. I understand the requirements of being a witness and I confirm the following:
  - I have not been designated to make medical decisions for the person who signed this Healthcare Power of Attorney and Living Will Combined Form;
  - I am not directly involved with providing healthcare to this person;
  - I am not related to this person by blood, marriage, or adoption;
  - I am not entitled to any part of this person's estate upon his death under a Will or by operation of law.

**OR**

- **Witness Verification:** The Principal is physically unable to sign or mark this document, so as witness I am verifying the Principal's desires as follows:

I believe that this Healthcare Power of Attorney and Living Will Combined Form accurately expresses the wishes communicated to me by the Principal of this document. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Healthcare Power of Attorney and Living Will Combined Form expresses his/her wishes and that he/she intends to adopt the Healthcare Power of Attorney and Living Will Combined Form at this time.

Witness Name (Printed): \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Witness Address: \_\_\_\_\_

Date: \_\_\_\_\_

2. **Notary Public:** Note: A Notary Public is only required if no witness signed above.

STATE OF ARIZONA                    )  
  ) ss.  
County of                                )

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Healthcare Power of Attorney and Living Will Combined Form has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above by blood, marriage, or adoption, nor am I a person designated to make medical decisions on his/her behalf. I am not directly involved in providing healthcare to the person signing. I am not entitled to any part of his/her estate under a Will now existing or by operation of law. In the event the person acknowledging this Healthcare Power of Attorney and Living Will Combined Form is physically unable to sign or mark this document, I verify that he/she directly indicated to me that this Healthcare Power of Attorney and Living Will Combined Form expresses his/her wishes and that he/she intends to adopt the Healthcare Power of Attorney and Living Will Combined Form at this time.

WITNESS MY HAND AND SEAL this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public \_\_\_\_\_ My Commission Expires \_\_\_\_\_