PART 1

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(1) **DESIGNATION OF AGENT.**

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

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work _____

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 _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work _____

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 _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work _____

(2) **AGENT'S AUTHORITY.**

My agent is authorized and directed to follow my individual instructions and my other wishes to the extent known to the agent in making all health care decisions for me. If these are not known, my agent is authorized to make these decisions in accordance with *my best interest*, including decisions to provide, withhold, or withdraw artificial hydration and nutrition and other forms of health care to keep me alive, except as I state here:

_____
_____
_____
_____

(Add additional sheets if needed.)

Under this authority, "best interest" means that the benefits to you resulting from a treatment outweigh the burdens to you resulting from that treatment after assessing

(A) the effect of the treatment on your physical, emotional, and cognitive functions;

(B) the degree of physical pain or discomfort caused to you by the treatment or the withholding or withdrawal of treatment;

(C) the degree to which your medical condition, the treatment, or the withholding or withdrawal of treatment, results in a severe and continuing impairment;

(D) the effect of the treatment on your life expectancy;

(E) your prognosis for recovery, with and without the treatment;

(F) the risks, side effects, and benefits of the treatment or the withholding of treatment; and

(G) your religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE.**

Except in the case of mental illness, my agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

In the case of mental illness, unless I mark the following box, my agent's authority becomes effective when a court determines I am unable to make my own decisions, or, in an emergency, if my primary physician or another health care provider determines I am unable to make my own decisions.

If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

(4) **AGENT'S OBLIGATION.**

My agent shall make health care decisions for me in accordance with this durable 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.

(5) **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 under (1) above, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making health care decisions, you do not need to fill out this part of the form.

If you do fill out this part of the form, you may strike any wording you do not want. There is a state protocol that governs the use of do not resuscitate orders by physicians and other health care providers. You may obtain a copy of the protocol from the Alaska Department of Health and Social Services. A "do not resuscitate order" means a directive from a licensed physician that emergency cardiopulmonary resuscitation should not be administered to you.

(6) **END-OF-LIFE DECISIONS.**

Except to the extent prohibited by law, 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: (Check only one box.)

[ ] (A) Choice To Prolong Life I want my life to be prolonged as long as possible within the limits of generally accepted health care standards; *OR*

[ ] (B) Choice Not To Prolong Life I want comfort care only and I do not want my life to be prolonged with medical treatment if, in the judgment of my physician, I have *(check all choices that represent your wishes)*

[ ] a condition of permanent unconsciousness: a condition that, to a high degree of medical certainty, will last permanently without improvement; in which, to a high degree of medical certainty, thought, sensation, purposeful action, social interaction, and awareness of myself and the environment are absent; and for which, to a high degree of medical certainty, initiating or continuing life-sustaining procedures for me, in light of my medical outcome, will provide only minimal medical benefit for me; or

[ ] a terminal condition: an incurable or irreversible illness or injury that without the administration of life-sustaining procedures will result in my death in a short period of time, for which there is no reasonable prospect of cure or recovery, that imposes severe pain or otherwise imposes an inhumane burden on me, and for which, in light of my medical condition, initiating or continuing life-sustaining procedures will provide only minimal medical benefit;

[ ] additional instructions:

_____

_____

_____

_____

(C) Artificial Nutrition and Hydration. If I am unable to safely take nutrition, fluids, or nutrition and fluids *(check your choices or write your instructions),*

[ ] I wish to receive artificial nutrition and hydration indefinitely;

[ ] I wish to receive artificial nutrition and hydration indefinitely, unless it clearly increases my suffering and is no longer in my best interest;

[ ] I wish to receive artificial nutrition and hydration on a limited trial basis to see if I can improve;

[ ] In accordance with my choices in (6)(B) above, I do not wish to receive artificial nutrition and hydration.

[ ] Other instructions _____
_____
_____

(D) Relief from Pain.

[ ] I direct that adequate treatment be provided at all times for the sole purpose of the alleviation of pain or discomfort; *or*

[ ] I give these instructions: _____
_____
_____

(E) **Should I become unconscious and I am pregnant,**

I direct that _____
_____
_____

(7) **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 _____
_____
_____

Conditions or limitations: _____
_____
_____
_____

(Add additional sheets if needed.)

PART 3

ANATOMICAL GIFT AT DEATH (OPTIONAL)

If you are satisfied to allow your agent to determine whether to make an anatomical gift at your death, you do not need to fill out this part of the form.

(8) UPON MY DEATH: (mark applicable box)

[ ] (A) **I give any needed organs, tissues, or other body parts,**
OR
[ ] (B) **I give the following organs, tissues, or other body parts only:**

_____

My gift under (A) or (B) above is for the following purposes (mark any of the following you want):

[ ] transplant;
[ ] therapy;
[ ] research;
[ ] education.

[ ] (C) **I refuse to make an anatomical gift.**

_____

PART 4

MENTAL HEALTH TREATMENT (OPTIONAL)

This part of the declaration allows you to make decisions in advance about mental health treatment.

The instructions that you include in this declaration will be followed **only if a court, two physicians that include a psychiatrist, or a physician and a professional mental health clinician believe that you are not competent and cannot make treatment decisions.** Otherwise, you will be considered to be competent and to have the capacity to give or withhold consent for the treatments.

If you are satisfied to allow your agent to determine what is best for you in making these mental health decisions, you do not need to fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(9) **PSYCHOTROPIC MEDICATIONS.** If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

[ ] I consent to the administration of the following medications:

_____

[ ] I do not consent to the administration of the following medications:

_____

Conditions or limitations: _____

_____

_____

(10) **ELECTROCONVULSIVE TREATMENT.** If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

[ ] I consent to the administration of electroconvulsive treatment.

[ ] I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: _____

_____

_____

(11) **ADMISSION TO AND RETENTION IN FACILITY.** If I do not have the capacity to give or withhold informed consent for mental health treatment, my wishes regarding admission to and retention in a mental health facility for mental health treatment are as follows:

[ ] I consent to being admitted to a mental health facility for mental health treatment for up to _____ days. (The number of days not to exceed 17.)

[ ] I do not consent to being admitted to a mental health facility for mental health treatment.

Conditions or limitations: _____

_____

_____

OTHER WISHES OR INSTRUCTIONS

_____

_____

_____

Conditions or limitations: _____

_____

_____

PART 5

PRIMARY PHYSICIAN (OPTIONAL)

(12) I DESIGNATE THE FOLLOWING PHYSICIAN AS MY PRIMARY PHYSICIAN:

Name of Physician _____
Address _____
City _____ State _____ Zip _____
Phone _____

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 _____
Address _____
City _____ State _____ Zip _____
Phone _____

(13) **EFFECT OF COPY.** A copy of this form has the same effect as the original.

(14) **SIGNATURES.**

In the presence of the witnesses or notary public, sign and date the form here:

_____ _____
Signature Date

_____
Printed Name

Address _____
City _____ State _____ Zip _____

(15) WITNESSES.

*This advance care health directive **will not** be valid for making health care decisions **unless** it is*

(A) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; the witnesses may not be a health care provider employed at the health

care institution or health care facility where you are receiving health care, an employee of the health care provider who is providing health care to you, an employee of the health care institution or health care facility where you are receiving health care, or the person appointed as your agent by this document; at least one of the two witnesses may not be related to you by blood, marriage, or adoption or entitled to a portion of your estate upon your death under your will or codicil; **or**

(B) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

WITNESS WHO IS NOT RELATED TO OR A DEVISEE OF THE PRINCIPAL:

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider providing health care to the principal;

(3) an employee of the health care institution or health care facility where the principal is receiving health care;

(4) the person appointed as agent by this document;

(5) related to the principal by blood, marriage, or adoption; or

(6) entitled to a portion of the principal's estate upon the principal's death under a will or codicil.

_____ _____

Signature of First Witness Date

_____

Printed Name

Address _____

City _____ State _____ Zip _____

WITNESS WHO MAY BE RELATED TO OR A DEVISEE OF THE PRINCIPAL

I swear under penalty of perjury under AS 11.56.200 that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider who is providing health care to the principal;

(3) an employee of the health care institution or health care facility where the principal is receiving health care; or
(4) the person appointed as agent by this document.

_____ _____
Signature of Second Witness Date

_____
Printed Name
Address _____
City _____ State _____ Zip _____

ALTERNATIVE NO. 2

ACKNOWLEDGEMENT BY NOTARY PUBLIC

State of Alaska _____ Judicial District
On this ____ day of _____, in the year _____, before me,
_____ (name of notary public) appeared
_____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that the person executed it.

(Seal)

_____
Signature of Notary Public