ADVANCE HEALTH CARE DIRECTIVE

FOR

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Form provided by:
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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. [*Note*: if you are married and want your spouse to act for you, you must list the spouse as your first designated agent]:

Name of Agent _____

Full Mailing Address _____

Phone Number(s) _____ Email _____

SECOND CHOICE: 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 second choice for agent:

Name of Second Choice _____

Full Mailing Address _____

Phone Number(s) _____ Email _____

THIRD CHOICE: If I revoke the authority of my agent and second choice agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my third choice for agent:

Name of Third Choice _____

Full Mailing Address _____

Phone Number(s) _____ Email _____

(2) AGENT'S AUTHORITY: My agent is authorized and directed to follow my instructions and my other wishes, to the extent known, in making all health care decisions for me. If my wishes are not known, my agent is authorized to make these decisions in accordance with my best interest.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE (choose one):

◯ My agent's authority becomes effective when my primary or attending physician determines that I am unable to make my own health care decisions.

◯ My agent's authority to make health care decisions for me takes effect immediately.

PART 2: INSTRUCTIONS FOR HEALTH CARE

(4) END-OF-LIFE DECISIONS: Except to the extent prohibited by law, I direct that my health care agent follow my instructions as I have marked below. [*Note*: You may mark as many of the boxes below as you like]

☐ Permanent Coma: I want respect care only [treatment which shows respect for my body, such as keeping me clean] and I do not want my life to be prolonged with medical treatment if I am in a permanent coma (or vegetative state), which will last permanently without improvement. This decision not to provide other life-sustaining medical treatment must be made by my agent and my primary physician, in consultation with a neurologist, based on a high degree of medical certainty that I will not recover.

Additional Instructions:

☐ Permanent Coma – artificial feeding: If I am in a permanent coma or vegetative state and have been placed on respect care only, I direct that any device for artificial nutrition and hydration (such as a feeding tube) be withdrawn.

Additional Instructions:

☐ Terminal Condition: I want comfort care only and I do not want my life to be prolonged with medical treatment if I have an incurable or irreversible illness or injury, and without life-sustaining medical procedures it will result in my death in a short period of time [generally understood to be less than two months], and for which there is no reasonable prospect of cure or recovery. Comfort care means that I am to be given only those treatments which help keep me comfortable and pain-free. This determination must be made by my primary physician and my agent, based on a high degree of medical certainty.

Additional Instructions:

Artificial Nutrition and Hydration: if I am unable to safely take nutrition, fluids, or nutrition and fluids (choose only one, or write your instructions),

- ◯ I wish to receive artificial nutrition and hydration indefinitely;
- ◯ I wish to receive artificial nutrition and hydration unless it clearly increases my suffering and is no longer in my best interest; OR
- ◯ I wish to receive artificial nutrition and hydration only on a limited trial basis to see if I can improve.

Additional Instructions:

Relief from Pain: If my physician believes that I am unlikely to recover and I need serious treatment for pain, then (choose only one):

- ◯ I direct that treatment for alleviation of pain or discomfort should be provided even if it hastens my death; OR
- ◯ I direct that treatment for alleviation of pain or discomfort should only be provided to the extent it will not hasten my death.

Additional Instructions:

(5) MENTAL HEALTH: If I wish to allow my agent to make decisions regarding mental health treatment, I will execute a separate mental health document. At this time, I do NOT authorize my agent to consent to psychotropic medications, electro-convulsive treatments, or confinement in a mental institution against my wishes.

(6) 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:

PART 3: ANATOMICAL GIFT AT DEATH

These are my choices regarding organ and tissue donation:

(7) Upon my death: (choose only one)

◯ I refuse to make an anatomical gift (skip to Part 4).

◯ I give any needed organs, tissues, or other body parts.

◯ I give any needed organs, tissues, or other body parts, as long as it will not make me unsuitable for viewing.

◯ I give the following organs, tissues, or other body parts only:

If I have chosen to make an anatomical gift, my gift is for the following purposes (mark any of the following you want):

☐ (i) Transplant

☐ (ii) Therapy

☐ (iii) Research

☐ (iv) Education

PART 4: PRIMARY PHYSICIAN

(8) I designate the following physician, clinic, physician assistant, or nurse practitioner as my primary physician (Leave this part blank if you do not have one, in which case those decisions will be made by the attending physician):

Name of Physician _____

Full Mailing Address _____

Phone Number(s) _____

PART 5: SIGNATURE

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

(10) Sign and date the form here:

Date	Signature

Printed Name

Address, City, State, Zip code

STATE OF ALASKA)
)ss.
THIRD JUDICIAL DISTRICT)

On _____(date) before the undersigned notary public, the above-named person, known to or identified by me, signed this document.

Notary in and for the state of Alaska
My Commission Expires: _____