California Advance Health Care Directive

加州
醫療照護事前指示

This form was developed by the American Cancer Society-Northern California Chinese Unit volunteers in August, 2001, and it is provided by Herald Cancer Care Network. **California Residents need to fill out the English version for legal purposes.**

本醫療照護事前指示由美國癌症協會北加州華人分會義工於2001年8月翻譯編制，由角聲癌友關懷網提供。**美國加州居民請務必填寫英文原文表格方具法律效力**。

ADVANCE HEALTH CARE DIRECTIVE

What is an Advance Health Care Directive?

The Advance Health Care Directive is your written or oral instruction to caregivers regarding which specific medical treatments you do or do not want to be performed in situations where you are not able to speak for yourself – for example, if you are unconscious, in a coma, too ill to communicate your wishes- or when you have chosen someone you trust to make these decisions for you.

By law, you have the legal right to provide these instructions to caregivers or an agent that you choose while you are capable of doing so, not only at end of life. If you choose an agent to make these decisions for you, that person's responsibility is to make sure your wishes are carried out.

The federal law, the Patient Self-Determination Act, requires health care facilities that receive Medicaid and Medicare funds to inform patients of their rights to execute advance health care directives.

Why do I need an advance health care directive?

There are several reasons why it is helpful to complete an advance health care directive:

1. You will protect your moral and legal right to determine what care you want and do not want;
2. What you want done will be clearer to your loved ones and to those treating you;
3. It will reduce conflict among your loved ones about what should be done;
4. It will lessen anxiety and guilt for loved ones and caregivers who may have to make life-and-death decisions regarding your care;
5. It will lessen you and your family's financial burden by avoiding the cost of unwanted treatments;
6. It will reduce fears you might have about being "over-treated";
7. If you want, you can also give instructions regarding the donation of your organs after you die.

INSTRUCTIONS FOR THE ADVANCE HEALTH CARE DIRECTIVE FORM

If you use this form, follow the instructions to complete or modify any part of it.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another person as an agent to make health care decisions for you if you become incapable of making your own decisions or you want someone else to make these decisions for you, even though you are still capable of making them yourself. You may name an alternative agent to act for you in case your first choice is not willing, able or reasonably available to make these decisions for you.

If you choose an agent, that person can not be your primary care provider, an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider, or an employee of the health institution where you are receiving care, unless that person is related to you or is one of your co-workers.

You may limit the authority of your agent or you may allow your agent to make all health care decisions for you. There is a place on this form to limit the authority of your agent. You may cross out Part 1 of this form (except item #6) if you do not want to have an agent represent you.

Part 2 of this form provides you an opportunity to give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or to include any additional wishes. If you want your agent to determine what is best for you in making end-of-life decisions, you can still fill out Part 2 of this form to guide your agent in making these decisions.

After completing this form, sign and date it at the end. This form must be signed by two qualified witnesses or acknowledged before a notary public. If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign on the “Statement of Patient Advocate or Ombudsman”. Give a copy of the signed and completed form to your physician, to your health care institution and your health care agent. You should talk to your health care agent to make sure that he or she understand your wishes and is willing to take the responsibility. You also should let your family members and close friends know your wishes regarding end-of-life care. You have the right to revoke this advance health care directive or replace this form at any time, as long as you have capacity.

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

Part 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) **Designation of Agent**: I designate the following individual as my agent to make health care decisions for me:

_____
(name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____ _____ _____
(home phone) (cellular phone) (work phone)

Optional: If I revoke my agent's authority or if my agents is not willing, able, or reasonably available to make a health-care decision for me, I designate as my **first alternate agent**:

_____
(name of individual you choose as first alternate agent)

_____
(address) (city) (state) (zip code)

_____ _____ _____
(home phone) (cellular phone) (work phone)

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 of individual you choose as second alternate agent)

_____
(address) (city) (state) (zip code)

_____ _____ _____
(home phone) (cellular phone) (work phone)

(2) **Agent's Authority**: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, **Except** as I state here :

_____
_____
_____
(add additional sheets if needed)

(3) **When Agent's Authority Becomes Effective** : 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. **If I initial this box [ ], my agent's authority to make health care decisions for me takes effective immediately.**

(4) **Agent's Obligation**: My agent shall make health care decisions for me in accordance with this 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.

My agent will have the right to:

(a) Consent or refuse to consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
(b) Select or discharge health care providers and institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures and programs of medication;
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

_____ _____ _____
(date) (name) (signature)

(5) **Agent's Postdeath Authority**: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in (17) of this form :

_____
_____
_____

_____ _____ _____
(date) (name) (signature)

(6) I do not designate any individual as my agent to make health care decisions for me.

_____ _____ _____
(date) (name) (signature)

If you do not want to designate any individual as your agent to make any health care decision for you, you may cross out sections (1), (2), (3), (4) and (5).

(7) **Nomination of Conservator**: If a conservator 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 conservator, I nominate the alternate agents whom I have named, in the order designated.

Part 2: INSTRUCTIONS FOR HEALTH CARE

If the following statements reflect your wishes regarding life-support measures, please sign and date it. You may strike any wording you do not want.

When I become unable to speak for myself and write instructions about my medical care, I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have marked below:

Choose (8) or (9):

(8) **Choice To Prolong Life**: I choose to prolong my life even if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits. This choice applies only within the limits of generally accepted health care standards. _____ _____
(your signature) (date)

---------- OR ----------

(9) **Choice NOT To Prolong Life**: I choose not to prolong my life even if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits. _____ _____
(your signature) (date)

I not only request but demand that the following instructions for my care be followed by my family, friends, physicians, other care-givers, and health care institutions:

(10) **Food and Fluids**: If I am unable to swallow safely, I do not wish to prolong my life by the administration of food or fluids by any artificial means, neither by needle nor by tubes through mouth, nose, stomach or intestines. I wish appropriate medication for any discomfort caused as a result. It is my wish to die if nutrition cannot be provided in the normal manner. _____ _____
(your signature) (date)

(11) **Infection**: The only treatment I will accept for infection is for pain management. Infection likely to prove fatal should be left to run its course without treatment except for pain.

_____ _____
(your signature) (date)

(12) **Medical Intensive Care**: I demand narcotics and/or other medications for control of pain and suffering, but refuse to be transferred to the hospital for surgery or other interventions if the purpose is to prolong my life. I consider this "rescue" inappropriate.

_____ _____
(your signature) (date)

(13) **Hospice Care**: I want hospice care to be considered for me at the earliest appropriate time in the course of my illness or condition: this means that my physician(s) must be realistic in their prognosis - their evaluation of the prospects for meaningful improvement.

_____ _____
(your signature) (date)

(14) **Relief From Pain**: I want caring and supportive nursing and medical care including narcotics and/or other treatments to control pain and other suffering even if they might depress respiration or might hasten my death. My concerns are for comfort, personal hygiene, and consideration of the needs of my loved ones. _____ _____
(your signature) (date)

I wish to reemphasize that if I am unable to give informed consent to health care decisions, and if the best available medical opinion is that there is little or no likelihood that my illness or condition is reversible or will improve substantially, it is my wish to die in the normal course of events without benefit of life-prolonging medical intervention. I specifically do not want interventions including, but not limited to: dialysis, respirator /ventilator, cardiopulmonary resuscitation (CPR), pacemaker, transfusion.

(15) **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:

_____

_____

_____
(add additional sheets if needed)

_____ _____ _____
(date) (your name) (signature)

(16) I added _____ pages to my advance medical health care directive and the date I signed to each page was the same as the date I signed for this advance directive.

_____ _____
(your signature) (date)

Part 3: DONATION OF ORGANS AT DEATH (optional)

(17) Upon my death: (initial applicable box and strike any of the following you do not want)

( ) (a) I give any needed organs, tissues, or parts
( ) (b) I give the following organs, tissues, or parts only : _____
(c) My gift is for the following purposes:
( ) Transplant ( ) Therapy ( ) Research ( ) Education
( ) (d) I do not want to give any organs, tissues or parts for any purposes

_____ _____ _____
(date) (your name) (signature)

Part 4: PRIMARY PHYSICIAN (optional)

(18) I designate the following physician as my primary physician:

_____ _____
(name of physician) (work phone number)

_____
(address) (city) (state) (zip code)

Part 5: WITNESS AND SIGNATURE

(19) **Effect of Copy**: A copy of this form has the same effect as the original.

(20) **Signature**: Sign and date the form here:

_____ _____ _____
(date) (printed name) (signature)

_____
(address) (city) (state) (zip code)

(21) **Witnessing**: This advance health care directive will not be valid for making health care decisions unless it is either: (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; or (b) acknowledged before a notary public.

If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign the Statement of Witnesses and must also sign the Statement of Patient Advocate or Ombudsman declaration.

Alternative No. 1: Statement of Witnesses

" I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence*, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this health care directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly."

First Witness:

_____ _____ _____
(printed name of witness) (signature of witness) (date)

_____
(address) (city) (state)

Second Witness:

_____ _____ _____
(printed name of witness) (signature of witness) (date)

_____
(address) (city) (state)

Additional Witness Statement

At least one of the witnesses must sign the following declaration:

" I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law."

_____ _____ _____
(printed name of witness) (signature of witness) (date)

Statement of Patient Advocate or Ombudsman

" I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by section 4675 of the Probate Code. "

_____ _____ _____
(printed name of witness) (signature of witness) (date)

_____
(address) (city) (state)

Alternative No. 2: Notary Public

State of California)
) SS,
County of _____)

On _____ ,
(date)

before me, _____
(name and title of officer)

personally appeared _____ ,
(name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence*) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

_____
(signature of notary)

NOTARY SEAL

Statement of Patient Advocate or Ombudsman

" I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as witness as required by section 4675 of the Probate Code. "

_____ _____ _____
(printed name of witness) (signature of witness) (date)

_____
(address) (city) (state)

- The law allows one or more of the following forms of identification as convincing evidence of identity: a California driver's license or identification card or U.S. passport that is current or has been issued within five years, contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number; a foreign passport that has been stamped by the U.S. Immigration and Naturalization Service; a driver's license issued by another state or by an authorized Canadian or Mexican agency; or an identification card issued by another state or by any branch of the U.S. armed forces. If the principal is a patient in a skilled nursing facility, a patient advocate or ombudsman may rely on the representations of family members or the administrator or staff of the facility as convincing evidence of identity if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.

醫療照護事前指示

甚麼是“醫療照護事前指示”？

“醫療照護事前指示”是一個人一旦在無法自我表達希望獲得的醫療照護時，一份自己事前口述或書寫好的有關醫療照護方面的特別意願。例如:當您意識不清、昏迷或病重無法溝通時，醫療照護事前指示使得您能夠“說出”在醫療照護上的自我決定。您也可以指定一位您信任的人為您做醫療照顧方面的決定，稱為
“醫療照護授權書”，您指定的人稱為您的“醫療照護代理人”。

法律上，您有權利指示您接受醫療照護的醫療機構、醫護人員或代理人，在您自己無法做醫療照護決定的任何時候，不只限於生命的末期，按照醫療照護事前指示，執行您的意願。

美國聯邦法和州法律均訂有醫療照顧事前指示的使用規定。聯邦法的“病人自我決定條款 (the Patient Self-Determination Act)”要求接受聯邦醫療補助金(Medicare)和州醫療補助金(Medicaid)的醫療機構，告知病人有使用醫療照護事前指示的權益。

為什麼我們需要有一份醫療照護事前指示？

基於以下的幾項理由，我們需要在自己無法做醫療照護決定的情況發生以前，事前先準備好一份醫療照護事前指示：

1. 保護了當事者自我決定的道德和法律權益;
2. 減除了“不確定當事者本人意願”的問題;
3. 減少了家屬友人彼此間因意見不同造成的衝突；
4. 消除家屬和照顧者為當事者做生死決定時，可能產生的內心焦慮和矛盾內疚的心理；
5. 解除了當事者對於“接受過度無效治療的折磨”的畏懼;
6. 減除當事者及家屬對於長時間無效治療造成的經濟負擔;
7. 完成了當事者愛心捐贈器官組織的意願。

“醫療照護事前指示”表格說明

當您使用此表格時，您可以照表格說明填寫全部或做部份修改。

第一部份是關於醫療照護的授權，讓您，在自己無法做醫療照護上的各項決定時，指定另外一個人作為您的代理人，為您做醫療照護上的決定。或即使您現在可以做自我決定，也可以授權另外一個人為您做醫療照護方面的決定。如果您指定的第一位代理人不願意、不能夠或各種因素無法執行您的意願時，您可以指定第二位為您做決定。

如果您授權代理人為您做醫療照護方面的決定，您的代理人不可以是您的主治醫師、醫護人員、提供您醫療照護的醫院或安養院僱主或員工，也不可以是負責您醫療照護的療養院僱主或員工，除非您的代理人和您有親屬上的關係或是您的同事。

您可以簽署限制代理人的職權，或者您也可以讓您的代理人為您做所有的醫療照護決定。這份表格有一個空欄，讓您填寫對於代理人職權的限制。如果您不希望指定任何代理人，您可以劃“X”刪除第一部份(除了第六項)。

表格的第二部份是您對自己的醫療照護所表達的意願及特殊指示，關於您是否希望接受、拒絕或終止維持生命的各項治療，以及疼痛控制的措施。空欄處讓您添加或寫下您的其他意願。如果您讓代理人為您做生命末期照護方面的全權決定時，您仍可以填寫這部份的表格，讓您的代理人照您的指示執行。

完成這份表格後，在結尾簽署您的姓名和日期。這份表格必須有兩位合格證人或一位公證人的簽署。如果您是療養院的病人，人權維護者或病人權益保護者必須在人權維護者或病人權益保護者聲明一欄中簽名。將完成並簽好名的表格影印本分別給您的醫師、您的醫療院所、安(療)養院，以及您指定的醫療照護代理人各一份存檔。您應當和您的指定代理人討論，以確定他(她)瞭解您的意願並願意擔負這項責任。您也應讓其他的家屬友人知道您對生命末期照護方面的意願。只要您的意識清醒，有能力做此決定，則您有權在任何時候取銷或更改這份醫療照護事前指示。

加州醫療照護事前指示

第一部份: 醫療照護授權書

(1) **醫療照護授權代理人的指定:** 我指定下者做我的醫療照護授權代理人，為我做有關醫療照護方面的決定：

_____

(正楷書寫指定的代理人名字)

_____

(地址) (城市) (州) (郵遞區號)

_____

(住家電話) (手機電話) (工作電話)

自由填寫: 如果我取消對我的代理人所做的授權，或我的代理人不願意、不能或合理的原因而無法為我做有關醫療照護方面的決定時，我指定的**第一候補代理人**如下:

_____

(正楷書寫指定的第一候補代理人名字)

_____

(地址) (城市) (州) (郵遞區號)

_____

(住家電話) (手機電話) (工作電話)

自由填寫: 如果我取消對我的代理人及第一候選代理人所做的授權，或我的代理人及第一候選代理人不願意、不能或合理的原因而無法為我做有關醫療照護方面的決定時，我指定的**第二候補代理人**如下:

_____

(正楷書寫指定的第二候補代理人名字)

_____

(地址) (城市) (州) (郵遞區號)

_____

(住家電話) (手機電話) (工作電話)

(2) **代理人的職權:除了下列所做的陳述以外**，我授權我的代理人為我全權做醫療照護上的決定，包括提供、停止或終止人工方式的營養和水份補充，及所有其他方式的醫療照護以維持我的生命。

我不授權我的代理人為我做下列的決定：

_____

_____

(如果需要更多空白處填寫，請另加紙張)

(3) **代理人職權的生效時間:** 除非我在下面句子的括弧內簽字，否則當我的主治醫師宣判我不能自我做決定時，我的代理人的職權開始生效。
如果我在此括弧內簽字(　　)， 我的代理人為我做醫療照護的職權立即生效。

(4) **代理人的職責:** 我的代理人將依照此份醫療照護授權書，以及對我的其他意願的瞭解，為我做決定。我的代理人對於我的意願不清楚的部份，將以我的最大利益為考量。我的代理人在判定我的最大利益時，將根據他(她)對我的個人價值觀的瞭解做考慮。

當我無法對我自己的醫療及照顧做決定並無法給予書面同意時，我授權我的代理人全權做決定。他的權責將包括:

(a) 同意、拒絕同意、或取消同意任何維持、診斷或其他影響身體或心智狀況的醫療照護、治療、服務或醫療過程;
(b) 選擇、更換或拒絕醫療照護人員和醫療照護院所;
(c) 同意或不同意診斷測驗，外科手術和服藥計劃;
(d) 指示提供、不提供或終止人工方式的營養、水份補充和所有其他形式的醫療，包括心肺復甦術。

_____ _____ _____
(日期) (正楷書寫姓名) (簽名)

(5) **代理人對遺體處理的職權:** 除了我在下列及在第(17)項所做的指示以外，我授權我的代理人為我做死後捐贈器官組織、授權遺體解剖、以及指示遺體的處理。

_____
_____

_____ _____ _____
(日期) (正楷書寫姓名) (簽名)

(6) 我不指定任何代理人，為我做有關醫療照護方面的決定。

_____ _____ _____
(日期) (正楷書寫您的姓名) (您的簽名)

如果您不希望有指定代理人為您做決定，請刪除第一部份(1), (2), (3), (4) 和(5)的部份。

(7) **監護人的提名:** 如果法院需要指定一位我的監護人，我提名在此表格內所指定的代理人。如果我的代理人不願意、不能，或無法做我的監護人時，我提名在此表格內按順序排列的指定候補代理人。

第二部份: 醫療照護指示

如果下列陳述最能表達您的意願，請在每一項的下面正楷填寫您的姓名、日期及親筆簽名。您可以更改文字中的用句。

如果我無法自己做醫療決定，並填寫書面同意書時，我指示我的醫護人員和相關家屬友人照下列我所陳述的意願執行：

只能選擇第(8)項或第(9)項中的一者

(8) **選擇要延長生命**: 我希望延長我的生命，即使 (1) 我的疾病無法治癒，而且病況無法好轉，在相當短的時日內，我將因此死亡，(2) 我的意識不清，醫學上合理地確定我的意識無法再恢復，或 (3) 治療所可能承受的危險和負擔，超過期望的療效。 _____ _____
(您的簽名) (日期)

------- **或** -------

(9) **選擇不要延長生命**: 我不希望延長我的生命，如果 (1) 我的疾病無法治癒，而且病況無法好轉，在相當短的時日內，我將因此死亡，(2) 我的意識不清，醫學上合理地確定我的意識無法再恢復，或 (3) 治療所可能承受的危險和負擔，超過期望的療效。 _____ _____
(您的簽名) (日期)

我不僅請求並且要求我的家人、朋友、醫師、其他照顧人員、和醫護機構遵從我下列的指示：

(10) **食物和液體**: 如果我無法安全吞嚥，我不希望經由，靜脈點滴或口、鼻、胃或腸道插管灌食的人工方式，獲得食物或液體以延長我的生命。我希望獲得適當的藥物減除我的不舒服。如果無法經由正常的給予方式提供我的營養，我選擇死亡。 _____ _____
(您的簽名) (日期)

(11) **感染**: 我繼續接受的唯一治療是，減除因感染而造成的疼痛。除非造成疼痛，否則感染本身雖可能導致死亡，就聽其自然，而不要治療。

_____ _____
(您的簽名) (日期)

(12) **加強醫護方面：** 我要求麻醉性止痛藥和／或其他藥物控制我的疼痛或受苦，但是拒絕因為要延長我的生命，而將我轉診到醫院接受手術或做其他的醫療處理。我認為這樣的急救是不適當的。_____ _____
(您的簽名) (日期)

(13) **安寧照護：** 我希望在疾病狀況惡化期間，我的醫師能真實評估我的健康進展的情況，而儘早在適當時間提供我安寧照護的選擇。

_____ _____
(您的簽名) (日期)

(14) **疼痛的控制**：除了我在下面空欄內所做的陳述，我指示，任何時候， 減除疼痛和不適的治療應該提供給我，即使這些治療加速我的死亡。

_____ _____
(您的簽名) (日期)

我希望再度強調，當我的神智不再清醒，而且，如果我的醫師已確認我的神智能力無法再恢復，或恢復的可能性很少時，我希望死於自然的情況下，而不要接受延長生命的各項醫療措施。我特別不希望接受的醫療措施，包括：人工心肺復甦術、 人工呼吸器 、血液透析、心搏器和輸血。

(15) **其他意願**:（ 如果您不同意上述的任何一項，希望寫下自己的意願時，或如果除了上述的意願外，您希望再添加其他的指示，您可以寫在此欄。）我指示：

_____

_____

_____
(如果需要更多空白處填寫，請另加紙張)

_____ _____ _____
(日期) (正楷書寫您的名字) (您的簽名)

(16) 我添加了 _____ 頁的意願說明書在這份醫療照護事前指示內。每頁我的簽名日期和我簽醫療照護事前指示的日期相同。_____ _____
(您的簽名) (日期)

第三部份：遺體器官捐贈（自由填寫）

(17) 我希望死後，(請在您希望的項目上，簽您的姓名首字母，並劃除不要的部份)

(　) (a) 我捐贈任何需要的器官、組織、或部份身體。

(　) (b) 我只捐贈下列的器官、組織、或部份身體：_____

(c) 我捐贈器官組織的目的是為了:

(　)器官組織移植 (　)治療 (　)研究 (　)教育

(　) (d) 我不捐贈任何器官、組織、或部份身體。

_____ _____ _____

(日期) (正楷書寫姓名) (簽名)

第四部份: 主治醫師(自由填寫)

(18) 我指定下列醫師為我的主治醫師:

_____ _____

（醫師姓名） （工作電話）

_____

（地址） （城市） （州） （郵遞區號）

第五部份：簽名和見證手續

(19) **影印本的效力**: 這份表格的影印本與正本具有相同效力。

(20) **授權人簽名**: 請在表格的此欄填寫您的姓名、地址、簽名和日期：

_____ _____ _____

（日期） （授權人正楷姓名） （授權人簽名）

_____

（地址） （城市） （州） （郵遞區號）

(21) **見證手續**: 除非完成下列手續否則這份醫療照護事前指示所做的醫護決定將不具有效力：(a)您簽署這份文件時，有兩位您本人認識的合法成人在現場見證，或他們認識您的簽名；或(b)在公證人面前的公證。

如果您是療養院的病人，人權維護者或病人權益保護者必須在見證人聲明上簽名，而且也必須在下述“人權維護者或病人權益保護者聲明”上簽名。

第一種方式： 見證

“ 我在加州法律作偽證受懲罰之規定下宣誓（1）我認識簽署或承認此份醫療照護事前指示文件的人，或經由可靠的證據*，我證明此人的身份；(2)此人在我的面前簽署或承認此份醫療照護事前指示；(3）此人心智良好，沒有被強逼，被欺騙或受人影響；(4）我不是此份醫療照護事前指示中指定的代理人；(5）我不是此人的醫療照護人員，或此人就醫門診或醫院的僱員，我也不是社區老人療養院或安養院的僱主或僱員。”

第一見證人:

_____ _____ _____

（見證人正楷姓名） （見證人簽名） （日期）

_____

（地址） （城市） （州）

第二見證人:

_____ _____ _____

（見證人正楷姓名） （見證人簽名） （日期）

_____

（地址） （城市） （州）

附加證詞

至少有一位證人必須在下列陳述後簽名

“ 在加州法律作偽證受懲罰之規定下，我更進一步宣誓：我和簽署此份醫療照護事前指示文件的人沒有血親、姻親或領養關係，而且就我所知道，根據此人現存或由法律執行的遺書裏，我沒有資格繼承此人的任何遺產。”

_____ _____ _____

（見證人正楷姓名） （見證人簽名） （日期）

人權維護者或病人權益保護者聲明

“ 我在加州法律作偽證受懲罰規定下宣誓：我是加州耆老處指定的人權維護者或病人權益保護者，依遺囑認證法規第4675條的規定做見證人。”

_____ _____ _____

（見證人正楷姓名） （見證人簽名） （日期）

_____

（地址） （城市） （州）

第二種方式：公證

加州_____郡，

於_____(年、月、日)，

在我 _____ 的面前,
(寫上公證人的名字和頭銜)

親自到場的 _____
(寫上授權人的名字)

確實(或有可信的證據證明)是授權人本人，並已向我證明授權是依自己的意願訂立此授權書。

在此蓋章和手印證明

_____
(公證人簽名)

公證印章

人權維護者或病人權益保護者聲明

“ 我在加州法律作偽證受懲罰規定下宣誓：我是加州耆老處指定的人權維護者或病人權益保護者，依遺囑認證法規第4675條的規定做見證人。”

_____ _____ _____
（見證人正楷姓名） （見證人簽名） （日期）

_____
（地址） （城市） （州）

*法律允許下列證件均可作為有效的身份證明: 加州駕駛執照或身份證、現有或過去五年內領取的美國護照，或以下任何五年內頒發的、具有本人照片及描述、有本人簽名和證件號碼的証件: 具有美國移民局蓋章的外國護照、外州或加拿大、墨西哥官方機構發給的駕駛執照、外州或任何美國軍方分支機關簽發的證明卡、受監管下的犯人，應有管教部頒發的犯人身份證明卡。如果授權人是療養院的病人，人權維護者或病人權益保護者可以信任病人家屬、療養院僱主或僱員的代表,只要他們能提供授權人身份的合理證據，可為病人作身份證明。