OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

STATE OF ARIZONA
DURABLE HEALTH CARE POWER OF ATTORNEY

Instructions and Form

GENERAL INSTRUCTIONS: Use this Durable Health Care Power of Attorney 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 is 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. There are further instructions for you about signing this form on page three.

1. Information about me (the Principal):

My Name: _____ My Age: _____
My Address: _____ My Date of Birth: _____
_____ My Telephone: _____

2. Selection of my health care representative and alternate ("agent" or "surrogate")

I choose the following person to act as my representative to make health care decisions for me:

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
_____ Cell Phone: _____

I choose the following person to act as an alternate representative to make health care decisions on my behalf if the first representative is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
_____ Cell Phone: _____

3. I AUTHORIZE if I am unable to make medical care decisions for myself:

I authorize my health care representative to make health care decisions for me when I cannot make or communicate my own health care decisions due to mental or physical illness, injury, disability, or incapacity. I want my

representative to make all such decisions for me except those decisions that I have expressly stated in Part 4 below that I do not authorize him/her to make. If I am able to communicate in any manner, my representative should discuss my health care options with me. My representative should explain to me any choices he or she made if I am able to understand. I further authorize my representative to have all access to and copies of my "personal protected health care information and medical records". This appointment is effective unless and until it is revoked by me or by an order of a court.

The types of health care decisions I authorize to be made on my behalf include but are not limited to the following:

- To consent or to refuse medical care, including diagnostic, surgical, or therapeutic procedures;
- To authorize the physicians, nurses, therapists, and other health care providers of his/her choice to provide care for me, and to obligate my resources or my estate to pay reasonable compensation for these services;
- To approve or deny my admittance to health care institutions, nursing homes, assisted living facilities, or other facilities or programs. By signing this form I understand that I allow my representative to make decisions about my mental health care except that he or she cannot have me admitted to a structured treatment setting with 24-hour-a-day supervision and an intensive treatment program – called a "level one" behavioral health facility – using just this grant of authority;
- To have access to and control over my medical records and to have the authority to discuss those records with health care providers.

4. DECISIONS I EXPRESSLY DO NOT AUTHORIZE my Representative to make for me:

I do not want my representative to make the following health care decisions for me (describe or write in "not applicable"):

5. My specific desires about autopsy:

NOTE: Under Arizona law, an autopsy is not required unless the county medical examiner, the county attorney, or a superior court judge orders it to be performed. See the General Information document for more information about this topic. Initial or put a check mark by one of the following choices.

_____Upon my death I DO NOT consent to a voluntary autopsy.
_____Upon my death I DO consent to a voluntary autopsy.
_____My representative may give or refuse consent for an autopsy.

6. My specific desires about organ donation ("anatomical gift"):

NOTE: Under Arizona law, you may donate all or part of your body. If you do not make a choice, your representative or family can make the decision when you die. You may indicate which organs or tissues you want to donate and where you want them donated. Initial or put a check mark by A or B below. If you select B, continue with your choices.

____ **A.** I DO NOT WANT to make an organ or tissue donation, and I do not want this donation authorized on my behalf by my representative or my family.
____ **B.** I DO WANT to make an organ or tissue donation when I die. Here are my directions:

1. What organs/tissues I choose to donate: (Select a or b below)

○ **a.** Whole body
○ **b.** Any needed parts or organs:
○ **c.** These parts or organs only:

1) _____
2) _____
3) _____

2. What purposes I donate organs/tissue for: (Select a, b, or c below)

○ **a. Any** legally authorized purpose (transplantation, therapy, medical and dental evaluation, education or research, and/or advancement of medical and dental science).
○ **b.** Transplant or therapeutic purposes only.
○ **c.** Research Only
d. Other: _____

3. Which organization or person I want my parts or organs to go to:

○ **a.** I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:(name) _____
_____

○ **b.** I would like my tissues or organs to go to the following individual or institution:
_____

○ **c**. I authorize my representative to make this decision.

7. Funeral and Burial Disposition (Optional):

My agent has authority to carry out all matters relating to my funeral and burial disposition wishes in accordance with this power of attorney, which is effective upon my death. My wishes are reflected below:

NOTE: If you choose whole body donation, cremation is the only burial disposition available.

Place your initials by those choices you wish to select.

_____ Upon my death, I direct my body to be buried. (As opposed to cremated)
_____ Upon my death, I direct my body to be buried in _____
_____. (Optional directive)
_____ Upon my death, I direct my body to be cremated.
_____ Upon my death, I direct my body to be cremated with my ashes to be _____
_____. (Optional directive)
_____ My agent will make all funeral and burial disposition decisions. (Optional directive)

8. About a Living Will

NOTE: If you have a Living Will and a Durable Health Care Power of Attorney, **you must attach** the Living Will to this form. A Living Will form is available on the Attorney General (AG) web site. Initial or put a check mark by box A or B.

_____ **A.** I have SIGNED AND ATTACHED a completed Living Will in addition to this Durable Health Care Power of Attorney to state decisions I have made about end of life health care if I am unable to communicate or make my own decisions at that time.
_____ **B.** I have NOT SIGNED a Living Will.

9. About a Prehospital Medical Care Directive or Do Not Resuscitate Directive:

NOTE: A form for the Prehospital Medical Care Directive or Do Not Resuscitate Directive is available on the AG Web site. Initial or put a check mark by box A or B.

____ A. I and my doctor or health care provider HAVE SIGNED a Prehospital Medical Care Directive or a Do Not Resuscitate Directive on Paper with ORANGE background in the event that 911 of Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

____ B. I have NOT SIGNED a Prehospital Medical Care Directive or Do Not Resuscitate Directive.

10. HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT/REPRESENTATIVE

_____ (Initial) I intend for my agent to be treated as I would with respect to my rights regarding the use and disclosure of my individually identifiable health information or medical records. This release authority applies to information governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 USC 1320d, 45 CFR 160-164.

SIGNATURE OR VERIFICATION

A. I am signing this Durable Health Care Power of Attorney as follows:

My Signature:_____ Date: _____

B. I am physically unable to sign this document, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Durable Health Care Power of Attorney accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Durable Health Care Power of Attorney at this time. He/she is physically unable to sign or mark this document at this time, and I verify that he/she directly indicated to me that the Durable Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Health Care Power of Attorney at this time.

Witness Name (printed):_____

Signature:_____ 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 health care at the time this form is signed.

A. Witness: I certify that I witnessed the signing of this document by the Principal. The person who signed this Durable Health Care Power of Attorney appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness and I confirm the following:

- I am not currently designated to make medical decisions for this person.
- I am not directly involved in administering health care to this person.
- I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
- I am not related to this person by blood, marriage or adoption.

Witness Name (printed): _____

Signature:_____ Date:_____

Address: _____

_____

Notary Public (NOTE: If a witness signs your form, you DO NOT need a notary to sign):

STATE OF ARIZONA) ss
COUNTY OF _____)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Durable Health Care Power of Attorney 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, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing health care 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 Durable Health Care Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that this Durable Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Health Care Power of Attorney at this time.

WITNESS MY HAND AND SEAL this_____day of_____, 20_____

Notary Public_____My Commission Expires: _____

OPTIONAL:
STATEMENT THAT YOU HAVE DISCUSSED YOUR HEALTH CARE CHOICES FOR THE FUTURE WITHYOUR PHYSICIAN

NOTE: Before deciding what health care you want for yourself, you may wish to ask your physician questions regarding treatment alternatives. This statement from your physician is not required by Arizona law. If you do speak with your physician, it is a good idea to have him or her complete this section. Ask your doctor to keep a copy of this form with your medical records.

On this date I reviewed this document with the Principal and discussed any questions regarding the probable medical consequences of the treatment choices provided above. I agree to comply with the provisions of this directive, and I will comply with the health care decisions made by the representative unless a decision violates my conscience. In such case I will promptly disclose my unwillingness to comply and will transfer or try to transfer patient care to another provider who is willing to act in accordance with the representative's direction.

Doctor Name (printed):_____

Signature:_____Date:_____

Address:_____

_____

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

STATE OF ARIZONA
DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY

Instructions and Form

GENERAL INSTRUCTIONS: Use this Durable Mental Health Care Power of Attorney form if you want to appoint a person to make future mental health care decisions for you if you become incapable of making those decisions for yourself. The decision about whether you are incapable can only be made by a specialist in neurology or an Arizona licensed psychiatrist or psychologist who will evaluate whether you can give informed consent. Be sure you understand the importance of this document. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson, and a lawyer before you sign this form. 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. There are more instructions about signing this form on page 3.

1. Information about me: (I am called the "Principal")

My Name:_____ My Age: _____
My Address:_____ My Date of Birth: _____
_____ My Telephone: _____

2. Selection of my health care representative and alternate: (Also called an "agent" or "surrogate")

I choose the following person to act as my representative to make mental health care decisions for me:

Name: _____ Home Phone:_____
Address: _____ Work Phone:_____
_____ Cell Phone:_____

I choose the following person to act as an alternate representative to make mental health care decisions for me if my first representative is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone:_____
Address: _____ Work Phone:_____
_____ Cell Phone:_____

3. Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my mental health care representative to make on my behalf if I become incapable of making my own mental health care decisions due to mental or physical illness, injury, disability, or incapacity. If my wishes are not clear from this Durable Mental Health Care Power of Attorney or are not otherwise known to my representative, my representative will, in good faith, act in accordance with my best interests. This appointment is effective unless and until it is revoked by me or by an order of a court. My representative is authorized to do the following which I have initialed or marked:

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (Cont'd)

☐ **A. About my records:** To receive information regarding mental health treatment that is proposed for me and to receive, review, and consent to disclosure of any of my medical records related to that treatment.

☐ **B. About medications:** To consent to the administration of any medications recommended by my treating physician.

☐ **C. About a structured treatment setting:** To admit me to a structured treatment setting with 24hour-a-day supervision and an intensive treatment program licensed by the Department of Health Services, which is called an inpatient psychiatric facility.

☐ **D. Other:** .

4. Durable Mental health treatments that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None") _____

5. Revocability of this Durable Mental Health Care Power of Attorney: This mental health care power of attorney or any portion of it may not be revoked and any designated agent may not be disqualified by me during times that I am found to be unable to give informed consent. However, at all other times I retain the right to revoke all or any portion of this mental health care power of attorney or to disqualify any agent designated by me in this document.

6. Additional information about my mental health care treatment needs (consider including mental or physical health history, dietary requirements, religious concerns, people to notify and any other matters that you feel are important): _____

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT/REPRESENTATIVE

_____ **(Initial)** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

SIGNATURE OR VERIFICATION

A. I am signing this Durable Mental Health Care Power of Attorney as follows:

My Signature: _____ Date: _____

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (Last Page)

B. I am physically unable to sign this document, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Durable Mental Health Care Power of Attorney accurately expresses the wishes communicated to me by the Principal of this document. He/she intends to adopt this Durable Mental Health Care Power of Attorney at this time. 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 Durable Mental Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Mental Health Care Power of Attorney at this time.

Witness Name (printed): _____

Signature: _____ 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 health care at the time this document is signed.

A. Witness: I affirm that I personally know the person signing this Durable Mental Health Care Power of Attorney and that I witnessed the person sign or acknowledge the person's signature on this document in my presence. I further affirm that he/she appears to be of sound mind and not under duress, fraud, or undue influence. He/she is not related to me by blood, marriage, or adoption and is not a person for whom I directly provide care in a professional capacity. I have not been appointed to make medical decisions on his/her behalf.

Witness Name (printed): _____

Signature: _____ Date: _____

Address: _____

_____

B. Notary Public: (NOTE: If a witness signs your form, you DO NOT need a notary to sign)

STATE OF ARIZONA) ss
COUNTY OF _____)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Durable Mental Health Care Power of Attorney 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, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing care as a professional 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 Durable Mental Health Care Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that the Durable Mental Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Mental Health Care Power of Attorney at this time

WITNESS MY HAND AND SEAL this____ day of_____, 20___

Notary Public: _____ My commission expires: _____

OPTIONAL: REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I accept this appointment and agree to serve as agent to make mental health treatment decisions for the Principal. I understand that I must act consistently with the wishes of the person I represent as expressed in this Durable Mental Health Care Power of Attorney or, if not expressed, as otherwise known by me. If I do not know the Principal's wishes, I have a duty to act in what I, in good faith, believe to be that person's best interests. I understand that this document gives me the authority to make decisions about mental health treatment only while that person has been determined to be incapacitated which means under Arizona law that a specialist in neurology or a licensed psychiatrist or psychologist has the opinion that the Principal is unable to give informed consent.

Representative Name (printed): _____

Signature: _____ Date: _____

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

LIVING WILL (End of Life Care)
Instructions and Form

GENERAL INSTRUCTIONS: Use this Living Will form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. It is your written directions to your health care representative if you have one, your family, your physician, and any other person who might be in a position to make medical care decisions for you. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you complete and sign this Living Will.

If you decide this is the form you want to use, complete the form. **Do not sign the Living Will until** your witness or a Notary Public is present to watch you sign it. There are further instructions for you about signing on page 2.

IMPORTANT: If you have a Living Will and a Durable Health Care Power of Attorney, you must attach the Living Will to the Durable Health Care Power of Attorney.

1. **My information:** (the "Principal")
   Name:_____ Age:_____
   Address: _____ Date of birth: _____
   _____ Phone: _____

2. My decisions about end of life care:

NOTE: Here are some general statements about choices you have as to health care you want at the end of your life. They are listed in the order provided by Arizona law. You can initial any combination of paragraphs A, B, C, and D. **If you initial Paragraph E, do not initial any other paragraphs.** Read all of the statements carefully before initialing to indicate your choice. You can also write your own statement concerning life-sustaining treatments and other matters relating to your health care at Heading 3 of this form.

_____ **A. Comfort Care Only:** 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 in an attempt to protect and enhance the quality of life without artificially prolonging life.)

_____ **B. Specific Limitations on Medical Treatments I Want:** (NOTE: Initial or mark one or more choices, talk to your doctor about your choices.) If I have a terminal condition, or am in an irreversible coma or a persistent vegetative state that my doctors reasonably believe 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:**

_____1.) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock, and artificial breathing.
_____ 2.) Artificially administered food and fluids.
_____ 3.) To be taken to a hospital if it is at all avoidable.

_____ **C. Pregnancy:** Regardless of any other directions I have given in this Living Will, 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.

_____ **D. Treatment Until My Medical Condition is Reasonably Known:** Regardless of the directions I have made in this Living Will, 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.

_____ **E. Direction to Prolong My Life:** I want my life to be prolonged to the greatest extent possible.

3. Other Statements Or Wishes I Want Followed For End of Life Care:

NOTE: You can attach additional provisions or limitations on medical care that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

___ **A.** I have not attached additional special provisions or limitations about End of Life Care I want.
___ **B.** I have attached additional special provisions or limitations about End of Life Care I want.

SIGNATURE VERIFICATION

A. I am signing this Living Will as follows:

Signature:_____ Date:_____

B. I am physically unable to sign this Living Will, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Living Will accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Living Will at this time. 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 Living Will expresses his/her wishes and that he/she intends to adopt the Living Will at this time.

Witness Name (printed):_____

Signature: _____Date:_____

SIGNATURE OF WITNESS OR NOTARY PUBLIC

NOTE: At least one adult witness OR a Notary Public must witness you signing this document. 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 health care at the time this document is signed.

A. Witness: I certify that I witnessed the signing of this document by the Principal. The person who signed this Living Will appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness. I confirm the following:

- I am not currently designated to make medical decisions for this person.
- I am not directly involved in administering health care to this person.
- I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
- I am not related to this person by blood, marriage, or adoption.

Witness Name (printed):_____

Signature:_____Date: _____

Address:_____

STATE OF ARIZONA LIVING WILL ("End of Life Care") (Last Page)

B. 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 Living Will 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, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing care as a professional 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 Living Will is physically unable to sign or mark this document, I verify that he/she directly indicated to me that the Living Will expresses his/her wishes and that he/she intends to adopt the Living Will at this time.

WITNESS MY HAND AND SEAL this _ day of _____, 20 _

Notary Public:_____My commission expires: _____

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

LETTER TO MY REPRESENTATIVE(S)
About Powers of Attorney Forms and Responsibilities

To My Representative:
Name:_____
Address: _____
_____

To My Alternate Representative:
Name:_____
Address: _____
_____

A. What I Ask You to Do For Me: Arizona law allows me to make certain medical and financial decisions as to what I want in the future if I become unable or incapable of making certain decisions for myself. I have completed the following document(s), and I want you to be my representative or alternate representative for the following purposes. (Initial or check one or more of the following):

____1. Durable Health Care Power of Attorney
____2. Durable Mental Health Care Power of Attorney

B. Why I Named an Alternate Representative: I chose two representatives in case one of you is unable to act for me when the time arises. I ask that you accept my selection of you as my representative or alternate. If you do not return the Power of Attorney form(s) and this letter to me or inform me differently, I will assume that you have agreed to be my representative.

C. Your Responsibilities as My Representative: By selecting you, I want you to make some very important decisions for me about my future health care needs if I become unable to make these decisions for myself. I might need you to carry out my medical choices as indicated in the enclosed Powers of Attorney, even if you do not agree with them. Please read the copies of the Powers of Attorney I am giving you. You will be my voice and will make medical decisions on my behalf. Other than what I have indicated in the Powers of Attorney as to my specific directions on certain issues, I am trusting your judgment to make decisions that you believe to be in my best interests. If at any time you do not feel that you can undertake this responsibility for any reason, please let me know. If you are unsure about any of my directions, please discuss them with me. If you are not willing to serve as my representative, please tell me so I can choose someone else to help me.

As to Health Care: You are not financially responsible for paying my health care costs merely by accepting this responsibility. Under Arizona law, you are not liable for complying with my decisions as stated in the Powers of Attorney or in making other health care decisions for me if you act in good faith.

D. What Else You Should Do: Please keep a copy of my Powers of Attorney and other documents in a safe place. Please read these documents carefully and discuss my choices with me at any time. I will give copies of my health care Powers of Attorney to my physician, and I will give copies of any or all of these Powers of Attorney to my family and any other representative I may choose. I authorize you to discuss with them the Powers of Attorney, including, as applicable, my medical situation, or any medical concerns about me. Please work with them and help them to act in accordance with my desires and in my best interests. I appreciate your support, and I thank you for your willingness to help me in this way.

Signature:_____ Date: _____

Printed Name:_____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE)

(IMPORTANT—THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. **IMPORTANT**: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to bevalid.

You can either attach a picture to this form, or complete the personal information. You must also complete the form and sign it in front of a witness. Your health care provider and your witness must sign this form.

1. My Directive and MySignature:

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient Signature:_____ Date: _____

PROVIDE THE FOLLOWING INFORMATION: **OR** **ATTACH RECENT PHOTOGRAPH HERE:**

My Date of Birth _

My Sex _

My Race _

My Eye Color _

My Hair Color _

2. Information About My Doctor and Hospice (if I am in Hospice)**:**

Physician:_____ Telephone: _____

Hospice Program, if applicable (name):_____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE) (Last Page)

3. Signature of Doctor or Other Health Care Provider:

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider:_____ Date: _____

4. Signature of Witness to MyDirective:

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document. 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 health care at the time this form is signed.

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Signature:_____ Date:_____