Health Care Power of Attorney* and *Living Will

Combined Form

I, _____, as principal(patient), designate

_____

Printed Name (agent) *Mailing Address (agent)*

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. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint _____ as my agent.

Printed name (secondary agent) *Mailing Address (secondary agent)*

Autopsy (under Arizona law an autopsy may be required)
If you wish to do so, reflect your desires below:
_____ 1. I do not consent to an autopsy.
_____ 2. I consent to an autopsy.
_____ 3. My agent may give consent to or refuse an autopsy.

(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 selection. 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.

_____ 2. If I am in a terminal condition or 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 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Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.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.

This combined health care directive is made under section 36-3221 and 36-3261, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

_____ _____
Signature of Principal (patient) Date

_____ _____
Printed Name (patient) Mailing Address

The maker of this document appears to be of sound mind and free from duress. It was subscribed and sworn before me this _____ day of _____.

Witness **or** Notary Public: _____

*(A **witness** or **notary** shall not be a person **(1)** designated to make medical decisions for the patient, **(2)** directly involved with providing health care to the patient, **(3)** related to the patient by blood, marriage or adoption nor **(4)** entitled to any part of the patient's estate.)*