DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For

Alaska Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ *Lifecare Directives* ~

Statutory Advance Directive

For

Alaska Residents

Statutory Compliant Advance Directive for Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Alaska Residents

______________________________ ______________________________
Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Alaska legislature has provided statutes guiding the construction of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." The content of this document was drawn from the Uniform Health Care Decisions Act, and should be in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless

you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in multiple parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

STATE OF ALASKA

ADVANCE HEALTH CARE DIRECTIVE

(Alaska Living Will and Power of Attorney for Health Care)

(Pursuant to AS Code §13.52.010 to §13.52.395)

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1. INTRODUCTION: *You have the right to give instructions about your own health care to the extent allowed by law. You also have the right to name someone else to make health care decisions for you to the extent allowed by law. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your health care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form if the form complies with the requirements of AS §13.52.*

Part 1 of this form lets you give specific instructions for any aspect of your health care to the extent allowed by law, except you may not authorize mercy killing, assisted suicide, or euthanasia. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief medication. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 2 of this form is a durable power of attorney for health care. A 'durable power of attorney for health care' means the designation of an agent to make health care decisions for you. Part 1 lets you name another individual as an agent to make health care decisions for you if you do not have the capacity to make your own decisions or if you want someone else to make those decisions for you now even though you still have the capacity to make those decisions. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you that you could legally make for yourself. This form has a place for you to limit the authority of your agent. You do not have to limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right, to the extent allowed by law, to:

a) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including the administration or discontinuation of psychotropic medication;
b) select or discharge health care providers and institutions;
c) approve or disapprove proposed 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; and
e) make an anatomical gift following your death.

Part 3 of this form lets you express an intention to make an anatomical gift following your death.

Part 4 of this form lets you make decisions in advance about certain types of mental health treatment.

Part 5 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as your agent to make sure that the person understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time, except that you may not revoke this declaration when you are determined not to be competent by a court, by two physicians, at least one of whom shall be a psychiatrist, or by both a physician and a professional mental health clinician. In this advance health care directive, 'competent' means that you have the capacity

(1) to assimilate relevant facts and to appreciate and understand your situation with regard to those facts; and
(2) to participate in treatment decisions by means of a rational thought process.

PART 1
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.

(1) 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 initialed below: (*initial 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 developed: (*initial all choices that represent your wishes*)

(i) _____ 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,

(ii) _____ 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, and 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;

and/or,

(iii) Additional instructions: ____

____

(C) ***Regarding Artificial Nutrition and Hydration***. If I am unable to safely and normally take nutrition (food) and/or fluids (water), I wish to:

(*initial only one*)

(i) _____ Receive artificial nutrition and hydration indefinitely;

(ii) _____ Receive artificial nutrition and hydration indefinitely, *unless* it clearly

increases my suffering and is no longer in my best interest;

(iii) _____ I wish to receive artificial nutrition and hydration on a limited, trial basis to see if I can improve;

(iv) _____ I do not wish to receive artificial nutrition and hydration at all if I am in a terminal or permanently unconscious condition.

and/or,

(v) 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: ________________

____

____

(2) 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: ____

____

____

____

____

Special conditions or limitations: ____

____

(*Add additional sheets if needed*.)

PART 2
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

(3) DESIGNATION OF AGENT. I designate the following individual as my agent to make health care decisions for me:

Name of Agent: ____

Address: ____

Telephone: Home: ____________________ Work: ______________________

Cell Phone or Pager: ____________________ E-mail: ______________________

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 of Alternate #1:____
Address: ____
Telephone: Home: ___________________ Work: _____________________
Cell Phone or Pager: ___________________ E-mail: ____________________

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 Alternate #2:____
Address: ____
Telephone: Home: ___________________ Work: _____________________
Cell Phone or Pager: ___________________ E-mail: ____________________

(4) 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 the 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.

(5) 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.

(6) 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 1 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.

(7) 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 above, in the order designated.

PART 3: (*OPTIONAL*)
ANATOMICAL GIFT AT DEATH

(*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: (*initial the applicable line*)

A) _____ I give any needed organs, tissues, or other body parts, OR

B) _____ I choose to give only the following organs, tissues, or other body parts:

____

C) _____ My gift is for the following purposes (*initial any that you want*):

(i) _____ transplant;
(ii) _____ therapy;
(iii) _____ research;
(iv) _____ education.

D) _____ I do not wish to make an anatomical gift.

PART 4: (*OPTIONAL*)
MENTAL HEALTH TREATMENT

(*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.*)

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 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: (*initial only one*)

_____ I consent to the administration of the following medications:

____

_____ I do not consent to the administration of the following medications:

____

Other 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: (*initial only one*)

_____ I do consent to the administration of electroconvulsive treatment.

_____ I do not consent to the administration of electroconvulsive treatment.

Other 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 may not to exceed 17.*)

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

Other conditions or limitations: ____

____

(12) OTHER MENTAL HEALTH WISHES OR INSTRUCTIONS: ____________________

____

____

PART 5: (*OPTIONAL*)
PRIMARY PHYSICIAN

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

Name: ____
Facility/Office: ____
Address: ____
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 alternate primary physician:

Name: ____
Facility/Office: ____
Address: ____
Phone: ____________________________

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

(15) SIGNATURES. Sign and date the form here:

Signature: ____
Print Full Name: ____
Date Completed: ____
Street Address: ____
City: ____________________________ County: _________________________
State: ____________________________ Zip Code: ________________________

(16) WITNESSES. This advance care health directive will not be valid for making health care decisions unless it is

A) signed by two 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

Statement of Witnesses

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, and 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.

1st Witness: ____
(Signature)

______________________________ ______________________________
(Name Printed) (Date)

____
(Residence Address and Judicial District)

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, and 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.

2nd Witness: ____
(Signature)

______________________________ ______________________________
(Name Printed) (Date)

____
(Residence Address and Judicial District)

ALTERNATIVE NO. 2

Certificate of Notarization

State of Alaska,

County/Judicial District:________________________ }

Place: ______________________________________

On this_______day of ________________________________, in the year______, before me (insert officer name/title): _____________________________________, personally appeared (insert name of Principal on line here):___________________________________, personally known to me (or proved to me on the basis of satisfactory evidence (describe:___________________________)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

____________________________________ **Notary Seal:**
Signature of Notary Public or Officer

____
Date Commission Expires