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 Arizona Residents

Standard State Statutory Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For Arizona Residents

Standard State Statutory 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 Arizona 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 Arizona legislature has designed both a living will and a Power of Attorney for Health Care for use by the public. Collectively, they are known "advance directives." As the content of these documents was designed by your state government, each is 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 it 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 two 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.

SECTION I:

LIVING WILL DECLARATION

(ARS. Title 36, Ch.32: Article 5: §36-3261 to §36-3262)

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1. INTRODUCTION: *Arizona statutes allow you to prepare a written statement to control future health care treatment decisions that may be made on your behalf, if you are ever unable to speak for yourself (§36-3261). 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 any 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.*

Living Will

Specific Treatment Wishes:

The following initialed statements represent my treatment wishes:

_____ 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**. However, I do **not** want the following treatment(s):

_____ 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 use 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**.

OR,

_____ 5. I want my life to be **prolonged** to the **greatest extent possible**.

Other or Additional Statements of Desires

I **have** _____ , or I **have not** _____ attached additional special provisions or limitations to this document to be honored in the absence of my being able to give health care directions. I have signed each, and the number of pages attached is:_____

Signature of Principal and Witnesses:

These directions express my legal right to accept or refuse treatment under the laws of Arizona. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

By signing below, I indicate that I am fully aware of the contents of this Document, and understand its full purpose, effect, and import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*Sign in the presence of a notary or a qualified witness, below*)

40. Signed: _____

Date: _____

Address: _____

Statement of Witness(es)

41. I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has had opportunity to read this document, and has affixed his/her signature or mark in my presence. This document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, undue influence or pressure to make specific choices or to sign the document. I am not the principal's agent (or an alternate), named to make decisions in this document. I have not signed the principal's signature (above) for or at the direction

of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for the principal, nor am I involved in directly physically caring for the principal, and to the best of my knowledge I am not entitled to any part of the principal's estate upon his or her death under a will or codicil now existing nor by any other operation of law.

(*Only <u>one</u> witness is required by Arizona law, but two are recommended. This document may be notarized, instead of being witnessed, if you prefer.*)

42. Witness: _____

Printed Name: _____

Address: _____

43. Witness: _____

Printed Name: _____

Address: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC (*optional*):
State of Arizona,

County of_____ }

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(s) is/are 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

_____
Date Commission Expires

SECTION II:
HEALTH CARE POWER OF ATTORNEY

Designation of Health Care Agent

(AC. Title:36 Ch.32: Art.2 §36-3221 to §36-3224)

44. INTRODUCTION: *This section lets you name a person (called an "agent" or "attorney-in-fact") to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice.*

Health Care Power of Attorney

1. **Nomination of Agent**:

I, _____, as principal, do herein designate and appoint:

Name of Agent: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ 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 this agent is unwilling or unable to serve or continue to serve, I do hereby appoint:

Alternate of Agent: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ as my alternate agent, to serve with all authorities originally granted.

I have _____, or I have not _____ completed and attached a living will for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the living will.

I have _____, or I have not _____ completed a pre-hospital medical care directive (refusing CPR) pursuant to section §36-3251, of the Arizona Revised Statutes.

2. **Autopsy** (*under Arizona law, in certain circumstances 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.

3. **Organ Donation** (*optional*)

Under Arizona law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law. Note: The donation elections you make in this health care power of attorney survive your death.

If any of the statements below reflect your desires, initial on the line next to that statement. You do **not** have to initial any of the statements. However, if you do **not** check **any** of the statements, your agent and your family **will** have the authority to make a gift of all or part of your body under Arizona law.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

_____

_____ Pursuant to Arizona law, I hereby give, effective on my death:

[_____] Any needed organ or parts. ***OR***,

[_____] Only the following parts or organs listed:

_____
_____
_____

~~ to be used for the following (*check only <u>one</u>*):

[_____] Any legally authorized purpose.

[_____] Transplant or therapeutic purposes only.

4. <u>Physician Affidavit</u> (*optional*)

Before initialing any choices above you may wish to ask questions of your physician regarding a particular treatment alternative. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his file.

My name is, Dr. _____, and I have reviewed this guidance document with _____, and have discussed and answered any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on the following date: _____.

I have agreed to comply with the provisions of this directive.

_____

Signature of Physician

Statement and Signature of Principal/grantor:

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

(*Do not sign until in the presence of a qualified witness, or a notary*)

Signed:_____ Date: _____

At: (City) _____ (State) _____

Statement of Witness(es)

I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has had opportunity to read this document, and has affixed his/her signature or mark in my presence. This document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, undue influence or pressure to make specific choices or to sign the document. I am not the principal's agent, named to make decisions in this document. I have not signed the principal's signature (above) for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for he principal, nor am I involved

in directly physically caring for the principal, and to the best of my knowledge I am not entitled to any part of the principal's estate upon his or her death under a will or codicil now existing nor by any other operation of law.

(*Only <u>one</u> witness is required by Arizona law, although two are recommended. Further, this document may be notarized instead of being witnessed if you desire*)

1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

Certificate of Acknowledgment of Notary Public:
State of Arizona,

County of_____ }

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(s) is/are 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

_____
Date Commission Expires

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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