Advance Directive – ALASKA

Name: _____ Date of Birth: ___/___/____

Telephone numbers: (home) _____; (cell) _____

Address _____

Email: _____

Complete at least **ONE** option from **Step 1** and **Step 2** and complete **Step 3**

Step 1: Choose a health care agent.

CHOOSE **ONE** OR **TWO** BOXES

☐ I choose _____; Relationship_____
(phone number - - and/or email_____) as my primary health care agent to speak for me in making health care decisions if I become unable to speak for myself.

☐ I choose _____ ; Relationship_____
(phone number - - and/or email_____) as my secondary health care agent who can speak for me in making health care decisions if I become unable to speak for myself and my primary health care agent is unable to serve.

Step 2: Provide guidance to my health care agent & doctors.

In working together to make treatment decisions and plans for my care, please consider my general preferences described below:

CHOOSE **ONE** BOX ONLY

☐ I am not sure at this time which statements below I most agree with. I trust my health care agent to do what is best for me.

☐ I want to continue living even if my quality of life seems low to others and I am unable to communicate with people. In general, I would accept support of my breathing, heart, and kidney function by machines that require me to be in a hospital or special care unit.

☐ Life is precious, but I understand that we all die sometime. I want to live as long as I can interact with others and can enjoy some quality of life. I would accept intensive treatments only if I had a reasonable chance of getting better. I would refuse long-term support by intensive medications or machines if my quality of life was poor and I was not able to communicate with people.

☐ It is most important to me to avoid suffering. I do not want extraordinary medical treatments, such as breathing machines or cardiopulmonary resuscitation (CPR). If my natural body functions fail, I would refuse treatments and choose to die naturally.

Is there anything your doctors should know about you to provide you with the best care possible?

_____

_____

Step 3: Complete and sign the form in front of EITHER 1) two witnesses OR 2) notary public

Signature _____ Date:_____

Address: _____

1. Option 1 – TWO Witnesses

STATEMENT OF FIRST WITNESS

I declare under penalty of perjury under the laws of Alaska, 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 sounds mind and under no duress, fraud, or undue influence, and that I am not:

- a health care provider employed at the health care institution or health care facility where the principal is receiving health care;
- an employee of the health care institution or health care facility where the principal is receiving health care;
- the person appointed as agent by this document;
- related to the principal by blood, marriage or adoption; or
- entitled to a portion of the principal's estate upon the principal's death under a will or codicil

Signature: _____

Print Name: _____ Date:_____

Address: _____

STATEMENT OF SECOND WITNESS

I swear under penalty of perjury under the laws of the state of Alaska, AS 11.56.200, that the principal is personally known to me, that they 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:

- a health care provider employed at the health care institution or health care facility where the principal is receiving health care;
- an employee of the health care provider who is providing health care to the principal;
- an employee of the health care institution or health care facility where the principal is receiving health care; or
- the person appointed as agent by this document;

Signature:_____

Print Name:_____ Date:_____

Address: _____

2. Option 2 – Notary

State of Alaska
County of _____

I certify that I know or have satisfactory evidence that _____ signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.
(Notary Seal)

Date: _____
Signature of Notary Public: _____
Title: _____
My appointment expires: _____

Name: _____ Date of Birth: _____

Instructions for Step 1: Appointing a health care agent.

Name someone you trust to make health care choices for you if you are unable to make your own decisions. Provide name and contact information for this person, along with one additional individual

Choose a family member or friend who:

- Is 18 or older and knows you well
- Is willing to do this for you
- Is able to make difficult decisions based on your wishes
- Will effectively communicate the information you provide in this packet to health

Your representative cannot be your doctor or someone who works at the hospital or clinic where you are receiving care unless he or she is a member of your family.

Your health care representative can:

- Decide where you will receive care
- Select or dismiss health care providers
- Say yes/no to medications, tests, treatments
- Take legal action to carry out your wishes

Your health care representative CANNOT authorize:

- Psycho-surgery
- Sterilization
- Abortion
- Removal of organs

except where the above procedures are necessary to preserve the life of the patient or to prevent serious impairment to the patient's health

Instructions for Step 2: Information for my health care agent & doctors in making decisions for my care.

Indicate your health care wishes

1. Select one of the choices to provide guidance concerning life support treatments. Below is some information about some life support treatments that may or may not be successful in helping you live longer.

   CPR or cardiopulmonary resuscitation: This may involve (1) Pressing hard on your chest to keep your blood pumping, (2) Electrical shocks to jump-start your heart, (3) Medicines in your veins.

   Ask your health care providers for more information as needed.

