## HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

My name is: First Middle initial Date of Birth Last PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me: Name and relationship of individual designated as health care agent Street Address City State Zip Home Phone Cell Phone E-mail If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent: and relationship of individual designated as health care agent Name Street Address City State Zip Home Phone Cell Phone E-mail AGENT'S AUTHORITY AND OBLIGATION: My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: 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. If I mark this box, my agent's authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care. I can revoke this authority at any time as long as I have mental capacity. PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.) A. END OF LIFE DECISIONS • If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR • If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR • If the likely risks and burdens of treatment would outweigh the expected benefits. **THEN** 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 marked below: Check only one of the following boxes. You may also initial your selection. I want to stop or withhold medical treatment that would prolong my life. OR I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

YOUR NAME:		
Print Your Full Name	Date of Birth	Date
PART 2: INDIVIDUAL INSTRUCTIONS (CONTIN anything with which you do not	<b>IUED)</b> (You may modify or strit agree. Initial and date any mod	ke through difications.)
B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD Artificial nutrition and hydration must be provided, withheld or I have made in the preceding paragraph A unless I mark the foll	withdrawn in accordance with lowing box. st be provided under all circums	
C. RELIEF FROM PAIN:	iscomfort even if it might hasten	my death.
<ul> <li>D. OTHER</li> <li>_ If I mark this box, the additional instructions or information my care. (Sign and date each added page and attach to this formation in the care i</li></ul>	<u> </u>	orated into
<b>E. WHAT IS IMPORTANT TO ME:</b> (Optional. Add additional value and that make life worth living to me are: (examples: gard pating in family gatherings, attending church or temple):	,	
	I have attached addition	onal sheet/s
My thoughts about when I would not want my life prolonged by If I no longer have the mental capacity to make my own decision if I can no longer safely swallow, etc):		

additional sheet/s

I have attached

Print Your Full Name Y	Your Signature Date of	Birth Date
VITNESSES: CHOOSE EITHER OP	TION 1 OR 2, NOT BOTH.	
mportant: Witnesses cannot be your hear		
OPTION 1: WITNESSES		
(Witness 1) declare that the person completing the signed or acknowledged this power of attorney influence. I am not related by blood, marriage, or of her/his estate. I am not the person appointed as employee of a health-care provider or facility.	in my presence and appears to be of sound adoption, and to the best of my knowledge	d mind and under no undue e I am not entitled to any part
Witness #1 Print Name	Witness Signature	Date
Street Address	City	State Zip
ence. I am not the person appointed as agent by t	his document, and I am not a health-care p	provider, nor an employee of
health-care provider or facility.	his document, and I am not a health-care p	provider, nor an employee of
	his document, and I am not a health-care p  Witness Signature	Date
health-care provider or facility.		
health-care provider or facility.  Witness #2 Print Name	Witness Signature	Date
health-care provider or facility.  Witness #2 Print Name  Street Address	Witness Signature	Date
Witness #2 Print Name  Street Address  OPTION 2: NOTARY PUBLIC  State of Hawai'i, (City and) County of On this day of	Witness Signature	Date  State Zip  before me, e of notary public) appear
Witness #2 Print Name  Street Address  OPTION 2: NOTARY PUBLIC  State of Hawai'i, (City and) County of On this day of	Witness Signature  City	Date  State Zip  before me, e of notary public) appear own to me (or proved to a d to thispage HawaiJudicial Circuit
Witness #2 Print Name  Street Address  OPTION 2: NOTARY PUBLIC  State of Hawai'i, (City and) County of  On this day of  on the basis of satisfactory evidence) to be Advance Health Care Directive dated on	Witness Signature  City	Date  State Zip  before me, e of notary public) appear own to me (or proved to a d to thispage HawaJudicial Circuit

A copy has the same effect as the original. www.kokuamau.org/resources/advance-directives Developed by the Executive Office on Aging and

Kōkua Mau - A Movement to Improve Care

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