ARIZONA MEDICAL LIVING WILL

This Medical Living Will is effective only while I am unable to make or communicate my healthcare decisions. I want everyone who cares for me to know what healthcare I want when I am not able to tell them myself. Please initial your preferences below.

1. _____ I want ALL life support treatments that my medical providers think might help. (*If you initial here, do not initial sections 2 or 3.)*

OR

2. _____ I want my medical providers to try life support treatments that they think might help, except I **do not want** the following treatments (check the boxes below):

CPR	☐ No	Dialysis	☐ No
Breathing Machine	☐ No	Antibiotics	☐ No
Feeding Tubes	☐ No	Blood Transfusions	☐ No
IV Fluids	☐ No		

3. _____ I DO NOT want life support treatments. I want to focus on being comfortable. I want to have a natural death.

Attached are additional directions to this Living Will: (Please check) ☐ DNR or Prehospital Medical Care Directive ☐ Arizona Provider Orders for Life-Sustaining Treatment ☐ Additional Statements/Desires:_____

_____

Organ Donation:
Do you want to be an organ, eye and/or tissue donor? (Initial Yes or No) Yes _____ No _____
If yes, circle what you want donated: any organ eye tissue or Specify: _____

Signature: This is a legal document. By signing it, you acknowledge that you have reviewed it carefully and it reflects your wishes. For this form to be used, you must be at least 18 years old and have a witness or notary watch you sign this form.

_____ _____ _____
Sign Your Name Today's Date Date of Birth

_____ _____ _____
Print Your First Name Print Your Last Name Address:

Witness
I was present when this Medical Living Will was signed and dated. The person seemed to be thinking clearly and was not forced to sign this Medical Living Will. I also promise that I am: 1) at least 18 years of age; 2) not the person's medical decision maker; 3) not part of the person's healthcare team; 4) not related by blood, marriage, or adoption; and 5) not going to get any part of the person's estate (such as money or property) after he/she dies.

_____ _____
Witness Signature Date

_____ _____ _____
Witness Print First Name Witness Print Last Name Address:

This document may be notarized instead of witnessed (optional).

State of Arizona)
County of _____)

On this _____ day of _____, 20____, before me personally appeared _____ whose identity was proven and he or she appeared to be of sound mind and free from duress, fraud or undue influence and he or she signed the above document.

_____
NOTARY PUBLIC

[Affix Seal Here]

We encourage you to also complete your Healthcare Power of Attorney. Talk about this form and your wishes about your healthcare with your Healthcare Power of Attorney, your medical provider(s), and your loved ones. Give each of them a copy of this form. You should review this form often and update as needed. You may cancel this form at any time.

ARIZONA HEALTHCARE POWER OF ATTORNEY WITH OPTIONAL MENTAL HEALTH AUTHORITY

This form lets you choose a medical decision maker (healthcare power of attorney) if you cannot communicate or make those decisions yourself. A medical decision maker must be at least 18 years of age and should be someone who knows your wishes and values and who you trust to carry out your wishes. It may be a family member or friend.

By signing this form, you give your medical decision maker full power to make healthcare decisions for you, including to: 1) Choose your medical providers, caregivers, treatment options and where you receive care; 2) Agree to, refuse or withdraw life support or medical treatment. You may also choose to give your medical decision maker the power to make mental health decisions for you; and 3) Decide what happens to your body after you die, such as funeral arrangements and organ donation, if you have not made other arrangements.

MEDICAL DECISION MAKER - I want this person to make my medical decisions if I am not able to make my own:

First Name _____ Last Name _____ Relationship _____ Phone _____

Address _____ Email Address _____

If the first person cannot do it, then I want this person to make my medical decisions:

First Name _____ Last Name _____ Relationship _____ Phone _____

Address _____ Email Address _____

MENTAL HEALTHCARE POWER OF ATTORNEY - This section must be initialed in front of a witness or a notary.

____ Initial here, to allow your medical decision maker the power to make mental healthcare decisions for you.

____ Initial here, to allow your medical decision maker the power to admit you to an inpatient or partial psychiatric hospitalization program.

If there are mental health decisions you do not want them to make, write them here: _____

This section may not be revoked if you are not able to make decisions for yourself, as determined by your physician.

This is a legal document. By signing it, you acknowledge that you carefully reviewed it and that the information reflects your wishes regarding who can make medical decisions for you, what those decisions should be, and that those wishes should be honored. ***In order for this form to be valid, you must be at least 18 years old and have one witness or a notary watch you sign this form.***

Sign Your Name _____ Today's Date _____ Date of Birth _____

Print Your First Name _____ Print Your Last Name _____ Address: _____

Witness

I was present when this Medical Living Will was signed and dated. The person seemed to be thinking clearly and was not forced to sign this Medical Living Will. I also promise that I am: 1) at least 18 years of age; 2) not the person's medical decision maker; 3) not part of the person's healthcare team; 4) not related by blood, marriage, or adoption; and 5) not going to get any part of the person's estate (such as money or property) after he/she dies.

Witness Signature _____ Date _____

Witness Print First Name _____ Witness Print Last Name _____ Address _____

This document may be notarized instead of witnessed (optional).

State of Arizona)

County of _____)

On this _____ day of _____, 20____, before me personally appeared _____ whose identity was proven and he or she appeared to be of sound mind and free from duress, fraud or undue influence and he or she signed the above document.

_____

NOTARY PUBLIC

[Affix Seal Here]

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE)

(IMPORTANT—THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. **IMPORTANT**: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

You can either attach a picture to this form, or complete the personal information. You must also complete the form and sign it in front of a witness. Your health care provider and your witness must sign this form.

1. My Directive and My Signature:

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient Signature:_____ Date: _____

Patient's Printed Name: _____

PROVIDE THE FOLLOWING INFORMATION: **OR**

My Date of Birth
My Sex
My Race
My Eye Color
My Hair Color

ATTACH RECENT PHOTOGRAPH HERE:

2. Information About My Doctor and Hospice (if I am in Hospice)**:**

Physician:_____ Telephone:_____

Hospice Program, if applicable (name):_____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE) (Last Page)

3. Signature of Doctor or Other Health Care Provider:

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider:_____ Date: _____

4. Signature of Witness to My Directive:

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Signature:_____ Date:_____