ALASKA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
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CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Alaska Advance Health Care Directive

This packet contains five parts, collectively called an **Advance Health Care Directive**, that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself, in addition to allowing you to make anatomical gifts and designate a physician to have primary responsibility for your health care.

Part 1 is a **Durable Power of Attorney for Health Care.** This form lets you name someone, called an agent, to make decisions about your medical care. A Durable Power of Attorney is typically used if you can no longer speak for yourself, but it also can be used 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 also name an alternate agent to act for you if your first choice is not willing, able, or available. However, your agent may not be an owner, operator, or employee of a health care institution where you are receiving care.

Part 2 contains your **Instructions for Health Care.** It lets you state your wishes about medical care and may be limited to take effect only if a specified condition arises (e.g., in the event that you develop a terminal condition and can no longer make your own medical decisions). Note that there is a state protocol that governs the use of “Do Not Resuscitate” orders by physicians and other health care providers.

Part 3 is an **Anatomical Gift at Death** form that lets you express an intention to make an Anatomical Gift.

Part 4 is a **Mental Health Treatment** form that lets you make decisions in advance about certain types of mental health treatment.

Part 5 is a **Primary Physician** form that lets you designate a physician to have primary responsibility for your health care.

Unless otherwise specified, your advance health care directive goes into effect when your doctor determines that you are unable to communicate your health care decisions. You do have the option of empowering your agent to make health care decisions for you immediately, even if you are still able to make decisions on your own.

Note: These documents will be legally binding only if the person completing them is a competent adult, at least 18 years old.

Completing Your Alaska Advance Health Care Directive

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

How do I make my Alaska Advance Health Care Directive legal?

The law requires that your advance health care directive be in writing, contain a date of execution, be signed by you (the "principal"), and witnessed by one of the following methods:

(1) Signed by at least two individuals who are personally known by the principal, each of whom either witnessed the signing of the instrument or the principal's acknowledgement of the signature of the advance directive. At least one of the individual witnesses must be someone who is (1) not related to you by blood, marriage, or adoption; and (2) not entitled to a portion of your estate upon death under a will at the time of the execution. The witnesses may not be: the agent, or a health care provider or employee of the health care institution or facility where you are receiving health care.

OR

(2) Acknowledged before a notary public at a place in the state.

Either option is available using this form.

Should I add personal instructions to my Alaska Advance Health Care Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

Completing Your Alaska Advance Health Care Directive (continued)

What if I change my mind?

Except in the case of mental illness, you may revoke the designation of your agent only by a signed writing or by personally informing your supervising health care provider. Except in the case of mental illness, you may revoke all or part of an advance health care directive (other than designating a new agent), at any time and in any manner that communicates your intent to revoke. Even if you are mentally ill, you may revoke your advance directive unless you have been determined to be incompetent by a court or by two physicians, one of whom is a psychiatrist or a professional mental health clinician.

What other facts should I know?

Your agent, or a guardian appointed by a court, may withhold or withdraw life-sustaining procedures when a qualifying condition exists when there is:

(1) Advance health care directive or other writing clearly expressing your intent that the procedures be withheld or withdrawn;

OR

(2) No advance health care directive or other writing that clearly expresses the patient's intent to the contrary, but withholding or withdrawing the procedure(s) would be consistent with your best interest.

EXPLANATION

OVERVIEW

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.

Part 1 of this form is a **Durable Power of Attorney for Health Care.** A "Durable Power of Attorney for Health Care" is 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.

AGENT POWERS

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.

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OVERVIEW (Continued)

INDIVIDUAL INSTRUCTIONS

Part 2 of this form lets you give specific instructions for any aspect of your health care to the extent allowed by law. 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.

ANATOMICAL GIFTS

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

MENTAL HEALTH TREATMENT

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

PRIMARY PHYSICIAN

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

EXECUTION

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 and alternate agent to make sure that the person understands your wishes and is willing to take the responsibility.

REVOCATION

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.

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PART 1: DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WRITE THE NAME OF YOUR AGENT

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

_____
(name of individual you choose as agent)

WRITE YOUR AGENT'S ADDRESS AND PHONE NUMBERS

_____ _____ _____ _____
(address) (city) (state) (zip code)

_____ _____
(home telephone) (work telephone)

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 alternate agent:

WRITE THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR ALTERNATE AGENT, IF YOU WANT TO DESIGNATE ONE

_____
(name of individual you choose as alternate agent)

_____ _____ _____ _____
(address) (city) (state) (zip code)

_____ _____
(home telephone) (work telephone)

ADD PERSONAL INSTRUCTIONS (IF ANY)
ADD ADDITIONAL SHEETS IF NEEDED

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:

_____

_____

_____

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PART 1: DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS (Continued)

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:

1. The effect of treatment on your physical, emotional and cognitive functions.
2. The degree of physical pain or discomfort caused to you by the treatment or the withholding or withdrawal of the treatment;
3. The degree to which your medical condition, the treatment, or the withholding or withdrawal of treatment, results in a severe and continuing impairment;
4. The effect of the treatment on your life expectancy;
5. Your prognosis for recovery, with and without the treatment;
6. The risks, side effects, and benefits of the treatment or the withholding of treatment; and
7. Your religious beliefs and basic values, to the extent that these may assist in determining benefits and burdens.

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. My agent's authority ceases to be effective upon determination that I have recovered my ability to make my own health care decisions. 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.

MARK THIS BOX ONLY IF YOU WOULD LIKE YOUR AGENT'S AUTHORITY TO TAKE EFFECT IMMEDIATELY

If I mark this box **[___],** my agent's authority to make health care decisions for me takes effect immediately.

AGENT'S OBLIGATIONS: 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 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are

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PART 1: DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS (Continued)

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.

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 agent whom I have named above.

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PART 2: INSTRUCTIONS FOR HEALTH CARE (OPTIONAL)

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.

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 marked below:

INITIAL ONLY ONE OF THESE BOXES

[____] 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

[____] 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:

INITIAL ALL BOXES THAT APPLY TO YOUR WISHES

[____] a condition of **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

ADD ANY ADDITIONAL INSTRUCTIONS THAT YOU HAVE

[____] 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, 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;

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PART 2: INSTRUCTIONS FOR HEALTH CARE (Continued)

INITIAL ONLY ONE

Artificial Nutrition and Hydration.
If I am unable safely to take nutrition or fluids:

[____] I wish to receive artificial nutrition and hydration indefinitely;

OR

[____] I wish to receive artificial nutrition and hydration indefinitely, unless it clearly increases my suffering and is no longer in my best interest;

OR

[____] I wish to receive artificial nutrition and hydration on a limited trial basis to see if I can improve;

OR

[____] I do not wish to receive artificial nutrition and hydration.

[____] Other instructions:

ADD ANY INSTRUCTIONS THAT YOU HAVE

_____
_____
_____

INITIAL ONLY ONE CHOICE THAT APPLIES AND ADD ANY INSTRUCTIONS THAT YOU HAVE

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:

_____
_____
_____

ADD YOUR INSTRUCTIONS

Should I become unconscious and am pregnant, I direct that

_____
_____
_____

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PART 2: INSTRUCTIONS FOR HEALTH CARE (Continued)

Optional 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 instructions to the above, do so here.

I direct that:

Conditions or limitations:

ADD OTHER INSTRUCTIONS, CONDITIONS, OR LIMITATIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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PART 3: ANATOMICAL GIFT AT DEATH (OPTIONAL)

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.

INITIAL ONLY ONE CHOICE

Upon my death:

[____] I give any needed organs, tissues, or other body parts,

OR

[____] I give the following organs, tissues, or other body parts only:

WRITE YOUR INSTRUCTIONS

_____
_____
_____
_____

OR

[____] I refuse to make an anatomical gift.

INITIAL ALL CHOICES THAT APPLY

My gift above is for the following purposes:

[____] transplant;
[____] therapy;
[____] research;
[____] education

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PART 4: MENTAL HEALTH TREATMENT (OPTIONAL)

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 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. If you do fill out this part of the form, you may strike any wording you do not want.

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: _____

ADD ANY CONDITIONS OR LIMITATIONS

Conditions or limitations:

_____

_____

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 consent to the administration of electroconvulsive treatment: _____

[____] I do not consent to the administration of electroconvulsive treatment: _____

ADD ANY CONDITIONS OR LIMITATIONS

Conditions or limitations:

_____

_____

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PART 4: MENTAL HEALTH TREATMENT (OPTIONAL)

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:

INITIAL ONLY ONE

[____] I consent to being admitted to a mental health facility for mental health treatment for up to _____ days. (The number of days not to exceed 17.) **OR**

[____] I do not consent to being admitted to a mental health facility for mental health treatment.

ADD ANY ADDITIONAL WISHES OR INSTRUCTIONS REGARDING YOUR MENTAL HEALTH TREATMENT

Other Wishes or Instructions:

_____
_____
_____
_____
_____
_____

ADD ANY ADDITIONAL CONDITIONS OR LIMITATIONS REGARDING YOUR MENTAL HEALTH TREATMENT

Conditions or limitations:

_____
_____
_____
_____
_____
_____

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PART 5: PRIMARY PHYSICIAN (OPTIONAL)

WRITE THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR PHYSICIAN

I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____ _____ _____
(address) (city) (state) (zip code)

_____ _____
(home telephone) (work telephone)

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 primary physician:

WRITE THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR ALTERNATE PHYSICIAN

_____
(name of physician)

_____ _____ _____ _____
(address) (city) (state) (zip code)

_____ _____
(home telephone) (work telephone)

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YOU MAY EXECUTE THIS ADVANCE DIRECTIVE IN ONE OF TWO WAYS

EXECUTION

This advance care health directive will not be valid for making health care decisions unless it is EITHER:

IF YOU CHOOSE TO SIGN WITH WITNESSES, USE ALTERNATIVE 1, BELOW

(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. (Use Alternative 1, below, if you decide to have your signature witnessed.)

OR

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW

(B) acknowledged before a notary public in the state. (Use Alternative 2, below, if you decide to have your signature notarized.)

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SIGN AND DATE YOUR ADVANCE DIRECTIVE

ALTERNATIVE NO. 1 (SIGN WITH WITNESSES)

IN WITNESS WHEREOF, I have hereunto signed my name this
_____ day of _____, _____.
(Day) (Month) (Year)

_____
(Signature of Principal)

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.

WITNESS 1 OF 2: DATE, SIGN AND PRINT YOUR NAME AND ADDRESS

_____ _____
(date) (signature of witness)

_____
(printed name of witness)

_____ _____ _____ _____
(address) (city) (state) (zip code)

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ALTERNATIVE NO. 1 (SIGN WITH WITNESSES) (Continued)

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 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;

WITNESS 2 OF 2: DATE, SIGN AND PRINT YOUR NAME AND ADDRESS

_____ _____

(date) (signature of witness)

_____

(printed name of witness)

_____ _____ _____ _____

(address) (city) (state) (zip code)

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SIGN AND DATE YOUR ADVANCE DIRECTIVE

ALTERNATIVE NO. 2 (SIGN BEFORE A NOTARY)

IN WITNESS WHEREOF, I have hereunto signed my name this
_____ day of _____, _____.
(Day) (Month) (Year)

_____
(Signature of Principal)

HAVE YOUR ADVANCE DIRECTIVE NOTARIZED BY A NOTARY PUBLIC

State of Alaska

_____ Judicial District

On this ____ day of _____, in the year _____,
(Day) (Month) (Year)

before me, _____,
(Name of Notary Public)

appeared _____,
(Principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that the person executed it.

Notary Seal

_____
(Signature of Notary Public)

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Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Alaska Advance Health Care Directive, Now What?

1. Your *Alaska Advance Health Care Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Alaska document.

7. Be aware that your Alaska document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives, called "do not resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   In Alaska, only a physician can issue a do not resuscitate order. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advance directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

- -

YES! I want to support the important work of the National Hospice Foundation.

$23	helps us provide free advance directives
$47	helps us maintain our free InfoLine
$64	helps us provide webinars to hospice professionals

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

AD_2016

OR donate online today: www.caringinfo.org/donate