PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENTable, or reasonably available to make a designate as my first alternate agent: (Name of individual you choose (address) (city)PRINT THEOPTIONAL: If I revoke the authority of m or if neither is willing, able, or reasonably	FOR HEALTH CARE         ate the following individual as for me:         choose as agent)         (state)       (zip code)         (work phone)		
PRINT THE         NAME, HOME         ADDRESS AND         HOME AND         WORK         TELEPHONE         NUMBERS OF         YOUR PRIMARY         AGENT         OPTIONAL: If I revoke my agent's author         ADDRESS AND         HOME AND         WORK         TELEPHONE         NUMBERS OF         YOUR PRIMARY         AGENT         OPTIONAL: If I revoke my agent's author         ADDRESS AND         HOME AND         WORK         TELEPHONE         NUMBERS OF         YOUR FIRST         AGENT         OPTIONAL: If I revoke the authority of nor if neither is willing, able, or reasonable	ate the following individual as for me: choose as agent) (state) (zip code) (work phone) ority of if my agent is not willing,		
PRINT THE       my agent to make health care decisions         NAME, HOME       (Name of individual you         ADDRESS AND       (adcress)         HOME AND       (adcress)         WORK       (adcress)         TELEPHONE       (home phone)         YOUR PRIMARY       OPTIONAL: If I revoke my agent's authority able, or reasonably available to make a designate as my first alternate agent:         MOME AND       (Name of individual you choose         WORK       (address)         TELEPHONE       (address)         NUMBERS OF       (address)         YOUR FIRST       (home phone)         NUMBERS OF       (home phone)         YOUR FIRST       (address)         ALTERNATE       OPTIONAL: If I revoke the authority of mor if neither is willing, able, or reasonable	for me: choose as agent) (state) (zip code) (work phone) prity of if my agent is not willing,		
ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF (OUR PRIMARY AGENT       (adc.re s)       (city)         PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT       OPTIONAL: If I revoke my agent's author able, or reasonably available to make a designate as my first alternate agent:         (Name of individual you choose WORK       (address)       (city)         YOUR FIRST ALTERNATE AGENT       (home phone)       OPTIONAL: If I revoke the authority of n or if neither is willing, able, or reasonably	(state) (zip code) (work phone) prity of if my agent is not willing,		
TELEPHONE         NUMBERS OF         OUR PRIMARY         AGENT         PRINT THE         NAME, HOME         ADDRESS AND         HOME AND         WORK         TELEPHONE         NUMBERS OF         YOUR FIRST         ALTERNATE         AGENT         OPTIONAL: If I revoke my agent's authority of more individual you choose         (Name of individual you choose         (home phone)         OPTIONAL: If I revoke the authority of more individual, able, or reasonable	rity of if my agent is not willing		
PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT       OPTIONAL: If I revoke my agent's author able, or reasonably available to make a designate as my first alternate agent:         (Name of individual you choose         (address)       (city)         (home phone)         OPTIONAL: If I revoke the authority of m or if neither is willing, able, or reasonably			
HOME AND WORK       (Name of individual you choose         TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT       (address)         OPTIONAL: If I revoke the authority of n or if neither is willing, able, or reasonable	OPTIONAL: If I revoke my agent's authority of if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:		
TELEPHONE       (address)       (city)         NUMBERS OF       (home phone)       (home phone)         ALTERNATE       OPTIONAL: If I revoke the authority of n or if neither is willing, able, or reasonab	(Name of individual you choose as first alternate agent)		
ALTERNATE AGENT OPTIONAL: If I revoke the authority of n or if neither is willing, able, or reasonab	(state) (zip code)		
OPTIONAL: If I revoke the authority of n or if neither is willing, able, or reasonab	(work phone)		
<b>NAME, HOME</b> ADDRESS AND	ly available to make a health		
HOME AND       (Name of individual you choose a WORK	(Name of individual you choose as second alternate agent)		
TELEPHONE     (address)       NUMBERS OF     (city)       YOUR SECOND     (city)	(state) (zip code)		
ALTERNATE AGENT (home phone)			

	CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE		
	(12) <b>EFFECT OF COPY:</b> A copy of this form has the same effect as the original.		
	(13) <b>SIGNATURE:</b> Sign and date the form here:		
SIGN AND DATE THE DOCUMENT	(date)	(sign your name)	
PRINT YOUR NAME AND ADDRESS	(address)	(print your name)	
	( <sup>,</sup> ity)	(state)	
	(14) <b>WITNESSES:</b> This advance bealth care directive will not be valid for making health care decisions unless it is either:		
	<ul> <li>(1) signed by two (2) qualified adult witness es who are personally known to you and who are present when you sign or acknowledge your signature; or</li> <li>(2) acknowledged before a notary public.</li> </ul>		
	ALTERNATIVE No. 1 STATEMENT OF WITNESSES I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud or undue influence, (4) that I am not a person appointed as an agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individuals's health care provider, the		
Both of your witnesses must agree with this statement			
HAVE YOUR WITNESSES SIGN AND DATE THE	operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.		
DOCUMENT AND THEN PRINT THEIR NAME AND	First Witness:		
ADDRESS	(date)	(signature of witness)	
© 2004 Last Acts Partnership, Inc.	(address)	(printed name of witness)	