

# ARIZONA

## Advance Directive

### Planning for Important Healthcare Decisions

***Caring Connections***  
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#### **CARING CONNECTIONS**

Caring Connections, 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.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

#### **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:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

## Using these Materials

### BEFORE YOU BEGIN

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

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. 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.
6. 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, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

## Introduction to Your Arizona Advance Directive

This packet contains the *Arizona Advance Directive for Healthcare* which protects 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.

The first part of this document is your state's *Living Will*. It lets you discuss your wishes about medical care in the event that you develop a terminal condition or are permanently unconscious and can no longer make your own medical decisions. The Living Will becomes effective when your doctor and one other physician document in your medical record that your doctor and one other physician document in your medical record that you are in a terminal condition or permanently unconscious.

The second part of this document permits the appointment of a *Healthcare Agent*. This section lets you name someone to make decisions about your medical care, including decisions about life-sustaining treatment, if you can no longer speak for yourself. It goes into effect when your doctor and one other physician document in your medical record that you are in a terminal condition or permanently unconscious.

*Note: This document will be legally binding only if the person completing the document is a competent adult.*

## Instructions for Completing Your Arizona Advance Directive for Healthcare

### How do I make my *Arizona Advance Directive for Healthcare* legal?

The law requires that you sign and date your Arizona Advance Directive for Healthcare in the presence of at least one (1) adult witness.

You can do this in either of two ways:

1. Sign and date your document in the presence of one witness, who must also sign the document and affirm that (a) he/she was present when you dated and signed the document, (b) you appeared to be of sound mind and free from duress at the time you signed the document, and (c) he/she does not fall into any of the categories of people who cannot be a witness.

Your witness **cannot** be:

- related to you by blood, marriage, or adoption,
- entitled to any part of your estate, by will or operation of law, at the time the document is signed,
- appointed as your agent, or
- involved with the provision of your healthcare at the time the document is signed.

OR

2. Have your signature witnessed by a notary public who is neither your agent nor a person involved with the provision of your healthcare at the time the document is signed. The notary must also affirm that (a) he/she was present when you dated and signed the document, (b) you appeared to be of sound mind and free from duress at the time you signed the document.

If you are physically unable to sign your Healthcare Power of Attorney, your witness or notary must add and sign a statement such as "The principal has directly indicated to me that the Living Will expresses his or her wishes and that the principal intends to adopt the Living Will at this time."

The law also requires that your appointed healthcare proxy and alternate healthcare proxy sign and date the document.

## **Instructions for Completing Your Arizona Advance Directive for Healthcare (continued)**

### **Can I add personal instructions to my *Living Will*?**

Yes. You can add personal instructions to your living will. For example, if there are any specific forms of treatment that you wish to refuse that are not already listed in the document, you may list them here.

You may also want to emphasize pain control by adding specific instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort." It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor for more information.

### **What if I change my mind?**

You may revoke your Advance Directive for Healthcare at any time by:

- obliterating, burning, tearing or otherwise destroying or defacing the document,
- executing, or directing another person to execute, a dated written revocation, or
- orally expressing your intent to revoke the Advance Directive for Healthcare in the presence of a witness, 19 years of age or older, who must sign and date a written confirmation that you made an oral revocation. An oral revocation becomes effective once the signed and dated confirmation is given to your doctor or healthcare provider, who will then make it a part of your medical record.

### **What other important facts should I know?**

The directions of a pregnant patient's Arizona Advance Directive for Healthcare authorizing the providing, withdrawal or withholding of life-sustaining treatments and artificially provided nutrition and hydration will not be honored due to restrictions in the state law.

## **Instructions for Completing Your Arizona Healthcare Power of Attorney**

### **How do I make my Arizona Healthcare Power of Attorney legal?**

The law requires that you sign and date your Healthcare Power of Attorney in the presence of at least one adult witness. You can do this in either of two ways:

1. Sign and date your document in the presence of one witness, who must also sign the document and affirm that (a) he/she was present when you dated and signed the document, (b) you appeared to be of sound mind and free from duress at the time you signed the document, and (c) he/she does not fall into any of the categories of people who cannot be a witness.

Your witness **cannot** be:

- related to you by blood, marriage, or adoption,
- entitled to any part of your estate, by will or operation of law, at the time the document is signed,
- appointed as your agent, or
- involved with the provision of your healthcare at the time the document is signed.

OR

2. Have your signature witnessed by a notary public who is neither your agent nor a person involved with the provision of your healthcare at the time the document is signed. The notary must also affirm that (a) he/she was present when you dated and signed the document, (b) you appeared to be of sound mind and free from duress at the time you signed the document.

If you are physically unable to sign your Healthcare Power of Attorney, your witness or notary must add and sign a statement such as "The principal has directly indicated to me that the Power of Attorney expresses his or her wishes and that the principal intends to adopt the Power of Attorney at this time."

### **Whom should I appoint as my proxy?**

A proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. (A proxy may also be called an "agent.") Your proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. You may also designate your proxy to provide for funeral and disposition arrangements in the event of your death.

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

## **Instructions for Completing Your Arizona Healthcare Power of Attorney (continued)**

### **Instructions for my healthcare proxy.**

One of the strongest reasons for naming a proxy is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. Caring Connections advises the use of the space on page 2 of 4 to provide instructions for your healthcare proxy including, giving authority to your healthcare proxy to make decisions about artificial food and water through a tube or IV.

We urge you to talk with your proxy about your future medical care and describe what you consider to be an acceptable "quality of life."

### **What if I change my mind?**

If you wish to revoke your Arizona Healthcare Power of Attorney, you may do so by:

- a written revocation,
- orally notifying your agent or healthcare provider of your revocation,
- executing a new Healthcare Power of Attorney, or
- any other act that demonstrates your intent to revoke your document.

INSTRUCTIONS

PRINT YOUR NAME

PRINT THE  
NAME, HOME  
ADDRESS, HOME  
AND WORK  
TELEPHONE  
NUMBERS OF YOUR  
AGENT

PRINT THE  
NAME OF YOUR  
ALTERNATE  
AGENT

**ARIZONA HEALTH CARE POWER OF ATTORNEY PAGE 1 OF 7**

1. HEALTH CARE POWER OF ATTORNEY

I, \_\_\_\_\_, as principal,  
(name)

designate

\_\_\_\_\_  
(name of agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_(home telephone number)

\_\_\_\_\_(work telephone number)

as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint

\_\_\_\_\_ as my agent.  
(alternate agent)

INSTRUCTIONS

INITIAL THE  
STATEMENT  
THAT APPLIES  
IN EACH  
PARAGRAPH

**ARIZONA HEALTH CARE POWER OF ATTORNEY PAGE 2 OF 7**

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I have \_\_\_\_\_ I have not \_\_\_\_\_ completed and attached a living will for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the living will.

I have \_\_\_\_\_ I have not \_\_\_\_\_ completed a prehospital medical directive pursuant to section 36-3251, Arizona Revised Statutes.



INSTRUCTIONS

AUTOPSY

INITIAL THE  
STATEMENTS  
THAT REFLECT  
YOUR WISHES  
(OPTIONAL)

**2. AUTOPSY  
(UNDER ARIZONA LAW AN AUTOPSY MAY BE REQUIRED)**

If any of the statements below reflects your wishes, initial on the line next to that statement. You do not have to initial any of the statements.

\_\_\_\_\_ 1. I do not consent to an autopsy.

\_\_\_\_\_ 2. I consent to an autopsy.

\_\_\_\_\_ 3. My agent may give consent to or refuse an autopsy.

ORGAN  
DONATION

3. ORGAN DONATION (OPTIONAL)

*(Under Arizona law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law. The donation elections you make below survive your death.)*

If any of the statements below reflects your desire, initial on the line next to that statement. You do not have to initial any of the statements. If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Arizona law.

\_\_\_\_\_ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

\_\_\_\_\_ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

\_\_\_\_\_ Pursuant to Arizona law, I hereby give, effective on my death:

\_\_\_\_\_ Any needed organ or parts.

\_\_\_\_\_ The following part or organs listed below:

for (initial one):

\_\_\_\_\_ Any legally authorized purpose.

\_\_\_\_\_ Transplant or therapeutic purposes only.

INITIAL THE  
STATEMENTS  
THAT REFLECT  
YOUR WISHES  
(OPTIONAL)

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Hospice and  
Palliative Care  
Organization  
2008 Revised.

PHYSICIAN  
AFFIDAVIT  
(OPTIONAL)

YOUR DOCTOR  
SHOULD COMPLETE  
THIS SECTION

4. PHYSICIAN AFFIDAVIT (OPTIONAL)

(Before initialing any choices in your Health Care Power of Attorney you may wish to ask questions of your physician regarding a particular treatment alternative. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his file.)

I, Dr. \_\_\_\_\_,  
have reviewed this guidance document and have discussed with

\_\_\_\_\_ any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on \_\_\_\_\_.  
(date)

I have agreed to comply with the provisions of this directive.

\_\_\_\_\_  
(signature of physician)

FUNERAL AND  
BURIAL  
DISPOSITION  
(OPTIONAL)

INITIAL THE  
STATEMENTS THAT  
REFLECT YOUR  
WISHES  
(OPTIONAL)

5. FUNERAL AND BURIAL DISPOSITION (OPTIONAL)

If any of the statements below reflects your desire, initial on the line next to that statement. You do not have to initial any of the statements.

My agent has authority to carry out all matters relating to my funeral and burial disposition wishes in accordance with this power of attorney, which is effective upon my death. My wishes are as follows:

\_\_\_\_\_ Up on my death, I direct my body to be buried (as opposed to cremated).

\_\_\_\_\_ Up on my death, I direct my body to be buried in \_\_\_\_\_  
(Optional directive).

\_\_\_\_\_ Up on my death, I direct my body to be cremated.

\_\_\_\_\_ Up on my death, I direct my body to be cremated, with my ashes to be \_\_\_\_\_ (optional directive).

\_\_\_\_\_ My agent may make all funeral and burial disposition decisions (optional directive).

## ARIZONA LIVING WILL PAGE 1 OF 2

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Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully before you initial your selection. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care under the section titled "Other or additional statements of desires."  
**You may initial any combination of paragraphs 1, 2, 3 and 4 but if you initial paragraph 5 the others should not be initialed.**

INITIAL ANY AND ALL PARAGRAPHS THAT REFLECT YOUR WISHES AND CROSS THROUGH STATEMENTS THAT DO NOT REFLECT YOUR WISHES

\_\_\_\_\_ 1. If I have a terminal condition I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

\_\_\_\_\_ 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following

- cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing; or
- artificially administered nutrition and hydration; or
- to be taken to a hospital if at all avoidable.

\_\_\_\_\_ 3. Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

\_\_\_\_\_ 4. Notwithstanding my other directions I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

\_\_\_\_\_ 5. Regardless of my condition, I want my life to be prolonged to the greatest extent possible.

YOU MAY ADD ADDITIONAL STATEMENTS OF DESIRES ON THE NEXT PAGE

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2008 Revised.

ARIZONA LIVING WILL PAGE 2 OF 2

YOU MAY ADD  
ADDITIONAL  
STATEMENTS OF  
DESIRES

Other or additional statements of desires:

SIGN AND  
DATE THE  
DOCUMENT

\_\_\_\_\_  
(signature of principal)

\_\_\_\_\_  
(date)

WITNESSING  
PROCEDURE

I affirm that this was signed or acknowledged and dated in my presence, and that the person signing this document (the principal) appears to be of sound mind and under no duress. I am not designated to make medical decisions on the principal's behalf. I am not directly involved with the provision of health care to the principal. I am not entitled to any portion of the principal's estate upon his or her decease, whether under any will or by operation of law. I am not related to the principal by blood, marriage, or adoption.

WITNESS  
MUST SIGN AND  
PRINT HIS/HER  
ADDRESSES

***NOTE: If the principal is physically unable to sign the Living Will, the witness or notary must add a statement the "The principal has directly indicated to me that this Living Will expresses his or her wishes and that the principal intends to adopt this Living Will at this time."***

Witness: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

*(Note: This document may be notarized instead of being witnessed.)*

## You Have Filled Out Your Advance Directive, Now What?

1. Your *Arizona Advance Directive for Healthcare* 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 proxy and alternate proxy, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. 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 proxy(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. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your Arizona document.
6. Be aware that your Arizona 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 "pre-hospital medical care directives," 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. The directives must be in the form required by the Arizona Department of Health Services, and must be signed by you, your physician and a witness.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**