**ADVANCE HEALTH CARE DIRECTIVE**

**FOR**

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Form provided by:

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**PART 1: DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS**

1. **DESIGNATION OF AGENT:** I designate the following individual as my agent to make health care decisions for me [NOTE: if you are married and want your spouse to act for you, you must list the spouse as your first designated agent]:

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|  |
| Name of Individual You Choose as Agent |
|  |
| Address, City, State, Zip Code |
|  |
| Phone Numbers, Email Address, Other Contact Info |

**SECOND CHOICE:** 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 second choice for agent:

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| Name of Individual You Choose as Agent |
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| Address, City, State, Zip Code |
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| Phone Numbers, Email Address, Other Contact Info |

**THIRD CHOICE:** If I revoke the authority of my agent and second choice agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my third choice for agent:

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| Name of Individual You Choose as Agent |
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| Address, City, State, Zip Code |
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| Phone Numbers, Email Address, Other Contact Info |

1. **AGENT’S AUTHORITY:** My agent is authorized and directed to follow my instructions and my other wishes, to the extent known, in making all health care decisions for me. If my wishes are not known, my agent is authorized to make these decisions in accordance with my best interest, and in keeping with my religious beliefs.
2. **WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE** [choose only one]:

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|  | My agent’s authority becomes effective when my primary or attending physician |
| determines that I am unable to make my own health care decisions, or when a Covid-19 or a similar SARS virus infection requires medical treatment at a health care provider, facility, hospital, or institution. | |

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|  | My agent’s authority becomes effective when any medical condition, medication, or |
| procedure(s) render me incapable of entering into legal contracts or operating motor vehicles, or when my primary or attending physician determines I am unable to make my own healthcare decisions. | |

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|  | My agent’s authority to make health care decisions for me take effect immediately. |

1. **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(s) whom I have named under (1) above, in the order designated.

**PART 2: INSTRUCTIONS FOR HEALTH CARE**

1. **HOSPITAL TREATMENT:** Except to the extent prohibited by law, I direct that my health care agent follows my instructions as I have marked below.

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|  | Access to Medical Records: I want my agent to exercise the right to request, receive, |
| examine, copy, and consent to the disclosure of medical or other health care information. In accordance with AS.13.52.070, I expect my health care providers, facilities, hospitals, and institutions to provide immediate access to my personal health care information to my agent. | |

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|  | Hospital Discharge: If my agent believes that the care provided to me is not in my best |
| interest, I authorize my agent to immediately request my discharge from that health care provider, facility, hospital, or institution, and seek health care treatment with another health care provider, facility, hospital, institution, or other location such as my home, as permitted by AS.13.52.060. | |

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|  | Isolation in Hospital or Health Care Facility: If isolation in a hospital or health care |
| facility precludes or prohibits visitation by my spouse, children, next of kin, or my agent, I authorize my agent to immediately request my discharge from that health care provider, facility, hospital, or institution and seek health care and treatment with another provider, facility, or institution, or other location such as my home, as permitted by AS.13.52.060. | |

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| Additional Instructions: |  |
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|  | Pain Relief: I shall always receive adequate treatment for the sole purpose of the |
| alleviation of pain or discomfort. | |

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| Additional Instructions: |  |
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|  | Immunizations and Vaccinations: Under no circumstances shall I be immunized or |
| administered any vaccine, except as allowed in writing by my agent. | |

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| Additional Instructions: |  |
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|  | Prohibited Agents: Under no circumstances shall a health care provider, facility, or |
| institution, act as my agent or make health care decisions on my behalf. | |

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| Additional Instructions: |  |
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1. **COVID-19 TREATMENT:** Except to the extent prohibited by law, I direct that my health care agent follow my instructions as I have marked below.

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|  | Early Treatment: I want early treatment to include those outlined in the most current |
| Front Line Covid-19 Critical Care Alliance I-Mask+ Prevention & Early Treatment Protocol for Covid-19. Prevention and Early Treatment Protocols should be followed closely. All OTC medicines and supplements are on hand and shall be administered according to FLCCC Protocols unless contraindications require alternative treatments. | |

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| Additional Instructions: |  |
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|  | Hospital Treatment: I want my hospital treatment to include those recommended |
| by the most current Front Line Covid-19 Critical Care Alliance MATH+ Hospital Treatment Protocol for Covid-19. I and my agent must be promptly informed of any denial by my health care providers, institutions, and facilities of any denial to comply with the instructions included in the MATH+ Hospital Treatment Protocol for Covid-19 per AS.13.52.060. | |

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| Additional Instructions: |  |
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|  | Medications & Treatments: I unequivocally decline without exception any |
| administration of Remdesivir. Under no circumstances will I be treated with any amount of Remdesivir. To the extent that hospital policies, indications, and contraindications allow, I want to be treated with Ivermectin, Hydroxychloroquine, and Casirivimab / Imdevimab, in addition to the treatments outlined in the MATH+ Hospital Treatment Protocol for Covid-19 and the FLCCC Guide to the Management of Covid-19. | |

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|  | Intubation and Ventilators: **Under no circumstances shall I be intubated or placed** |
| ***on a ventilator as treatment for Covid-19.*** Oxygen supplementation according to the MATH+ Hospital Treatment Protocol for Covid-19 shall be provided as needed. | |

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|  | Intubation and Ventilators: **Under no circumstances shall I be intubated or placed** |
| ***on a ventilator as treatment for Covid-19 until*** oxygen supplementation according to the MATH+ Hospital Treatment Protocol for Covid-19 has been provided needed. | |

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| Additional Instructions: |  |
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1. **END-OF-LIFE DECISIONS:** Except to the extent prohibited by law, I direct that my health care agent follow my instructions as I have marked below.

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|  | Permanent Coma: I want respect care only [treatment which shows respect for my |
| my body, such as keeping me clean] and I do not want my life to be prolonged with medical treatment if I am in a permanent coma (or vegetative state), which will last permanently without improvement. This decision not to provide other life-sustaining medical treatment must be made by my agent and my primary physician, in consultation with a neurologist, based on a high degree of medical certainty that I will not recover. | |

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| Additional Instructions: |  |
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|  | Permanent Coma – Artificial Feeding: If I am in a permanent coma or vegetative |
| state and have been placed on respect care only, I direct that any device for artificial nutrition and hydration (such as a feeding tube) be withdrawn. | |

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| Additional Instructions: |  |
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|  | Terminal Condition: I want comfort care only and I do not want my life to be prolonged |
| with medical treatment if I have an incurable or irreversible illness or injury, and without life-sustaining medical procedures it will result in my death in a short period of time [generally understood to be less than two months], and for which there is no reasonable prospect of cure or recovery. Comfort care means that I am to be given only those treatments which help keep me comfortable and pain-free. This determination must be made by my primary physician and my agent, based on a high degree of medical certainty. | |

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| Additional Instructions: |  |
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| Artificial Nutrition and Hydration: if I am unable to safely take nutrition, fluids, or |
| nutrition and fluids (check only one choice, or write your instructions), |

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|  |  | I wish to receive artificial nutrition and hydration indefinitely; |

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|  |  | I wish to receive artificial nutrition and hydration unless it clearly increases my |
| suffering and is no longer in my best interest; OR | | |

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|  |  | I wish to receive artificial nutrition and hydration only on a limited basis to see |
| if I can improve. | | |

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| Additional Instructions: |  |
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| Relief from Pain: |
| If my physician believes that I am unlikely to recover and I need serious treatment for pain, then: |

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|  | I shall always receive adequate treatment for the sole purpose of the alleviation of pain |
| or discomfort. | |

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|  | I want the minimum amount of pain treatment so my pain is treated without the loss of |
| my mental or cognitive abilities. | |

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| Additional Instructions: |  |
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1. **MENTAL HEALTH:** If I wish to allow my agent to make decisions regarding mental health treatment, I will execute a separate mental health document. At this time, I do NOT authorize my agent to consent to psychotropic medications, electro-convulsive treatments, or confinement in a mental institution against my wishes.

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|  | If, at any time, my health care provider, facility, or institution, or hospital prescribes |
| any mental health treatment, to include any psychotropic medications, electro-convulsive treatments, or confinement in a mental institution, I direct my agent immediately request my discharge from that health care provider, facility, hospital, or institution and seek health care treatment with another provider, facility, hospital, or institution, or another location such as my home, as permitted by AS.13.52.060. | |
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1. OTHER 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 to the instructions you have given above, do so here.

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| I direct that: |  |
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**PART 3: ANATOMICAL GIFT AT DEATH**

These are my choices regarding organ and tissue donation:

1. Upon my death: (choose only one)

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|  |  | I refuse to make an anatomical gift (skip to Part 4). |

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|  |  | I give any needed organs, tissues, or other body parts. |

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|  |  | I give any needed organs, tissues, or other body parts, as long as it will not |
| make me unsuitable for viewing. | | |

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|  |  | I give any needed organs, tissues, or other body parts only: |
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| If I have chosen to make an anatomical gift, my gift is for the following purposes (mark any of the following you want): |

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|  | (i) | Transplant |

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| --- | --- | --- |
|  | (ii) | Therapy |

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|  | (iii) | Research |

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|  | (iv) | Education |

**PART 4: PRIMARY PHYSICIAN**

1. I designate the following physician, clinic, physician assistant, or nurse practitioner as my primary physician (Leave this part blank if you do not have one, in which case those decisions will be made by the attending physician):

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
| Phone: |  |

**PART 5: SIGNATURE**

1. EFFECT OF COPY: A copy of this form has the same effect as the original.
2. Sign and date the form here:

|  |
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|  |
| Date Sign Your Name |
|  |
| Print Your Name |
|  |
| Address, City, State, Zip Code |

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| **STATE OF ALASKA** | **)** |
|  | **)ss.** |
| **THIRD JUDICIAL DISTRICT** | **)** |

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|  | On this |  | day of |  | | | , in the year |  | | , before me, |
|  | | | | | , appeared |  | | | , personally | |
| (insert name of notary) | | | | |  | (signer’s name) | | |  | |

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 freely.

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| Notary Seal |  | |
| Notary in and for the state of Alaska  My commission Expires: | |
|  |  |

**PART 5: SIGNATURE**

1. EFFECT OF COPY: A copy of this form has the same effect as the original.
2. Sign and date the form here:

|  |
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|  |
| Date Sign Your Name |
|  |
| Print Your Name |
|  |
| Address, City, State, Zip Code |

**FIRST WITNESS**

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.

|  |
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|  |
| Date First Witness Signature |
|  |
| Print Your Name |
|  |
| Address, City, State, Zip Code |

**SECOND WITNESS**

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.

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|  |
| Date Second Witness Signature |
|  |
| Print Your Name |
|  |
| Address, City, State, Zip Code |

**SIGNATURE INSTRUCTIONS**

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

1. ***Signed before a notary public in the state of Alaska.***
2. ***Signed by two qualified adult witnesses*** who are:
   1. personally ***known to you*** and
   2. who are ***present when you sign*** or acknowledge your signature
   3. the ***witnesses may not be***:
      1. the ***person appointed as your agent*** by this document;
      2. a ***health care provider*** employed at the health care institution or health care facility ***where you are receiving health care***
      3. ***an employee of the health care provider*** who is providing health care to you
      4. ***an employee*** of the health care institution or health care facility ***where you are receiving health care***
   4. ***at least one*** of the two witnesses ***may not be:***
      1. ***related to you*** by blood marriage, or adoption or
      2. ***entitled to a portion of your estate*** upon your death under your will or codicil

**To use a notary public**

1. ***Bring legal identification*** along with your Advanced Health Care Directive
2. Go to your local bank or credit union and ask for a notary service.
3. Go to a local mail vendor such as a UPS Store or FedEx/Kinkos store.
4. Search the web for notary services in your area.