ARIZONA MEDICAL LIVING WILL

This Medical Living Will is effective only while I am unable to make or communicate my healthcare decisions. If I'm so sick I could die soon, 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 <u>ALL</u> 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 ☐ POLST
☐ 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.

 Revised 10/20

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 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 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 Power of Attorney was signed and dated. The person seemed to be thinking clearly and was not forced to sign this Medical Power of Attorney. 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.
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]

 Revised 10/20