California Advance Health Care Directive

加州

醫療照護事前指示

This form is provided by the Chinese American Coalition for Compassionate Care (CACCC).

California residents will need to fill out the English version for legal purposes.

CACCC contact information: (866) 661-5687; Email: admin@caccc-usa.org; www.caccc-usa.org. (March, 2012)

本醫療照護事前指示由美華慈心關懷聯盟提供,美國加州居民請務必填寫英文表格方具法律效力。 美華慈心關懷聯盟聯絡電話: (866) 661-5687; admin@caccc-usa.org; www.caccc-usa.org (2012年3月)

醫療照護事前指示

甚麼是"醫療照護事前指示"?

"醫療照護事前指示"是一個人一旦在無法自我表達希望獲得的醫療照護時,一份自己事前口述或書寫好的有關醫療照護方面的特別意願。例如:當您意識不清、昏迷或病重無法溝通時,醫療照護事前指示使得您能夠"說出"在醫療照護上的自我決定。您也可以指定一位您信任的人為您做醫療照顧方面的決定,稱為"醫療照護授權書",您指定的人稱為您的"醫療照護代理人"。

法律上,您有權利指示您接受醫療照護的醫療機構、醫護人員或代理人, 在您自己無法做醫療照護決定的任何時候,不只限於生命的末期,按照醫療 照護事前指示,執行您的意願。

美國聯邦法和州法律均訂有醫療照顧事前指示的使用規定。聯邦法的"病人自我決定條款 (the Patient Self-Determination Act)"要求接受聯邦醫療補助金 (Medicare) 和州醫療補助金 (Medicaid) 的醫療機構,告知病人有使用醫療照護事前指示的權益。

為什麼我們需要有一份醫療照護事前指示?

基於以下的幾項理由,我們需要在自己無法做醫療照護決定的情況發生 以前,事前先準備好一份醫療照護事前指示:

- 1. 保護了當事者自我決定的道德和法律權益;
- 2. 減除了"不確定當事者本人意願"的問題:
- 3. 減少了家屬友人彼此間因意見不同造成的衝突;
- 4. 消除家屬和照顧者為當事者做生死決定時,可能產生的內心焦慮和 矛盾內疚的心理;
- 5. 解除了當事者對於"接受過度無效治療的折磨"的畏懼;
- 6. 減除當事者及家屬對於長時間無效治療造成的經濟負擔;
- 7. 完成了當事者愛心捐贈器官組織的意願。

ADVANCE HEALTH CARE DIRECTIVE

What is an Advance Health Care Directive?

The Advance Health Care Directive is your written or oral instruction to caregivers regarding which specific medical treatments you do or do not want to be performed in situations where you are not able to speak for yourself – for example, if you are unconscious, in a coma, too ill to communicate your wishes- or when you have chosen someone you trust to make these decisions for you.

By law, you have the legal right to provide these instructions to caregivers or an agent that you choose while you are capable of doing so, not only at end of life. If you choose an agent to make these decisions for you, that person's responsibility is to make sure your wishes are carried out.

The federal law, the Patient Self-Determination Act, requires health care facilities that receive Medicaid and Medicare funds to inform patients of their rights to execute advance health care directives.

Why do I need an advance health care directive?

There are several reasons why it is helpful to complete an advance health care directive:

- 1. You will protect your moral and legal right to determine what care you want and do not want:
- 2. What you want done will be clearer to your loved ones and to those treating you;
- 3. It will reduce conflict among your loved ones about what should be done;
- 4. It will lessen anxiety and guilt for loved ones and caregivers who may have to make life-and-death decisions regarding your care;
- 5. It will lessen you and your family's financial burden by avoiding the cost of unwanted treatments;
- 6. It will reduce fears you might have about being "over treated";
- 7. If you want, you can also give instructions regarding the donation of your organs after you die.

"醫療照護事前指示"表格說明

當您使用此表格時,您可以照表格說明填寫全部或做部份修改。

第一部份是關於醫療照護的授權,讓您在自己無法做醫療照護上的各項決定時,指定另外一個人作為您的代理人,為您做醫療照護上的決定。或即使您現在可以做自我決定,也可以授權另外一個人為您做醫療照護方面的決定。如果您指定的第一位代理人不願意、不能夠或各種因素無法執行您的意願時,您可以指定第二位為您做決定。

如果您授權代理人為您做醫療照護方面的決定,您的代理人不可以是您的主治醫師、醫護人員、提供您醫療照護的醫院或安養院僱主或員工,也不可以是負責您醫療照護的療養院僱主或員工,除非您的代理人和您有親屬上的關係或是您的同事。

您可以簽署限制代理人的職權,或者您也可以讓您的代理人為您做所有的醫療照護決定。這份表格有一個空欄,讓您填寫對於代理人職權的限制。如果您不希望指定任何代理人,您可以劃"X"刪除第一部份(除了第六項)。

表格的第二部份是您對自己的醫療照護所表達的意願及特殊指示,關於您是否希望接受、拒絕或終止維持生命的各項治療,以及疼痛控制的措施。空欄處讓您添加或寫下您的其他意願。如果您讓代理人為您做生命末期照護方面的全權決定時,您仍可以填寫這部份的表格,讓您的代理人照您的指示執行。

完成這份表格後,在結尾簽署您的姓名和日期。這份表格必須有兩位合格證人或一位公證人的簽署。如果您是療養院的病人,人權維護者或病人權益保護者聲明一欄中簽名。將完成並簽好名的表格影印本分別給您的醫師、您的醫療院所、安(療)養院,以及您指定的醫療照護代理人各一份存檔。您應當和您的指定代理人討論,以確定他(她)瞭解您的意願並願意擔負這項責任。您也應讓其他的家屬友人知道您對生命末期照護方面的意願。只要您的意識清醒,有能力做此決定,則您有權在任何時候取銷或更改這份醫療照護事前指示。

INSTRUCTIONS FOR THE ADVANCE HEALTH CARE DIRECTIVE FORM

If you use this form, follow the instructions to complete or modify any part of it.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another person as an agent to make health care decisions for you if you become incapable of making your own decisions or you want someone else to make these decisions for you, even though you are still capable of making them yourself. You may name an alternative agent to act for you in case your first choice is not willing, able or reasonably available to make these decisions for you.

If you choose an agent, that person can not be your primary care provider, an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider, or an employee of the health institution where you are receiving care, unless that person is related to you or is one of your co-workers.

You may limit the authority of your agent or you may allow your agent to make all health care decisions for you. There is a place on this form to limit the authority of your agent. You may cross out Part 1 of this form (except item #6) if you do not want to have an agent represent you.

Part 2 of this form provides you an opportunity to give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or to include any additional wishes. If you want your agent to determine what is best for you in making end-of-life decisions, you can still fill out Part 2 of this form to guide your agent in making these decisions.

After completing this form, sign and date it at the end. This form must be signed by two qualified witnesses or acknowledged before a notary public. If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign on the "Statement of Patient Advocate or Ombudsman". Give a copy of the signed and completed form to your physician, to your health care institution and your health care agent. You should talk to your health care agent to make sure that he or she understand your wishes and is willing to take the responsibility. You also should let your family members and close friends know your wishes regarding end-of-life care. You have the right to revoke this advance health care directive or replace this form at any time, as long as you have capacity.

加州醫療照護事前指示

第	一部份:	醫療具	召藩	授權	書
7	- LL 1/1 •	望 がいい	~~ PX	ソスツエ	目

(1) 醫療照護授權代理人的指定:	我指定下者做我的醫療照護授權代理人,為	寺
我做有關醫療照護方面的決定:		

我做有關實際照護力面的決及。			
(正楷書	寫指定的第一候補代理人名字〉)	
(地址)	(城市)	(州) (郵遞區號)	
(住家電話)	(手機電話)	(工作電話)	
自由填寫:如果我取消對我的代或合理的原因而無法為我做有關	, , , , , , , , , , , , , , , , , , , ,		,
理人如下:			

(正楷書寫指定的第一候補代理人名字)				
	(地址)	(城市)	(州) (郵遞區號)	
	(住家電話)	(手機電話)	(工作電話)	

自由填寫:如果我取消對我的代理人及第一候選代理人所做的授權,或我的代理人及第一候選代理人不願意、不能或合理的原因而無法為我做有關醫療照護方面的決定時,我指定的第二候補代理人如下:

(正楷書寫	指定的第一候補代理人名字)	
(地址)	(城市)	(州) (郵遞區號)	
(住家電話)	(手機電話)	(工作電話)	

(2)代理人的職權:除了下列所做的陳述以外,我授權我的代理人為我全權做醫療照護上的決定,包括提供、停止或終止人工方式的營養和水份補充,及所有其他方式的醫療照護以維持我的生命。

我不授權我的代理人為我做下列的決定:

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

Part 1: POWER OF ATTORNEY FOR HEALTH CARE

(I	name of individual you choose as age	ent)	
(address)	(city)	(state)	(zip code)
(dddic55)	(oity)	(state)	(Zip code)
(home phone)	(cellular phone)	(work p	phone)
Optional: If I revoke my ager vailable to make a health-ca	, , ,	•	
(name o	f individual you choose as first altern	ate agent)	· · · · · · · · · · · · · · · · · · ·
(address)	(oity)	(state)	(zip code)
(address)	(city)	(State)	(<u>L.p 3033</u>)
(home phone) Optional: If I revoke the auth	(cellular phone) ority of my agent and first a	alternate agent o	r if neither is
(home phone) Optional: If I revoke the auth villing, able, or reasonably a	(cellular phone) ority of my agent and first available to make a health c	alternate agent o	r if neither is
(home phone) Optional: If I revoke the auth villing, able, or reasonably as my second alternate age	(cellular phone) ority of my agent and first available to make a health c	alternate agent o are decision for r	r if neither is
(home phone) Optional: If I revoke the auth villing, able, or reasonably as my second alternate age	(cellular phone) ority of my agent and first available to make a health cent:	alternate agent o are decision for r	r if neither is
(home phone) Optional: If I revoke the authvilling, able, or reasonably as my second alternate age (name of integral (address)	(cellular phone) ority of my agent and first available to make a health cent:	alternate agent o are decision for r	r if neither is ne, I designat

(3)	代理人職權的生效時間:除非我在下面句子的括弧內簽字,否則當我的主治醫師宣判我不能自我做決定時,我的代理人的職權開始生效。如果我在此括弧內簽字(),我的代理人為我做醫療照護的職權立即生效。
(4)	代理人的職責: 我的代理人將依照此份醫療照護授權書,以及對我的其他意願的瞭解,為我做決定。我的代理人對於我的意願不清楚的部份,將以我的最大利益為考量。我的代理人在判定我的最大利益時,將根據他(她對我的個人價值觀的瞭解做考慮。
	當我無法對我自己的醫療及照顧做決定並無法給予書面同意時,我授權我的代理人全權做決定。他的權責將包括: (a) 同意、拒絕同意、或取消同意任何維持、診斷或其他影響身體或心智狀況的醫療照護、治療、服務或醫療過程; (b) 選擇、更換或拒絕醫療照護人員和醫療照護院所; (c) 同意或不同意診斷測驗,外科手術和服藥計劃; (d) 指示提供、不提供或終止人工方式的營養、水份補充和所有其他形式的醫療,包括心肺復甦術。
(5)	(日期) (正楷書寫姓名) (簽名) 代理人對遺體處理的職權: 除了我在下列及在第(17)項所做的指示以
	外,我授權我的代理人為我做死後捐贈器官組織、授權遺體解剖、以及指示遺體的處理。
	(日期) (正楷書寫姓名) (簽名)
(6)	我不指定任何代理人,為我做有關醫療照護方面的決定。

如果您不希望有指定代理人為您做決定,請刪除第一部份(1),(2),(3),(4)和(5)。

(您的簽名)

(正楷書寫您的姓名)

(日期)

(7) **監護人的提名:**如果法院需要指定一位我的監護人,我提名在此表格內 所指定的代理人。如果我的代理人不願意、不能,或無法做我的監護人時, 我提名在此表格內按順序排列的指定候補代理人。

effe care	ctive when my primar decisions unless I m	thority Becomes Effective: My agent's ry physician determines that I am unable nark the following box. If I initial this both care decisions for me takes effective	to make my own health ox [], my agent's
with my my dete	this power of attorne other wishes to the ex agent shall make hea ermines to be in my be	I: My agent shall make health care decisely for health care, any instructions I give extent known to my agent. To the extent alth care decisions for me in accordance est interest. In determining my best intellues to the extent known to my agent.	in Part 2 of this form, and my wishes are unknown, with what my agent
(a) (b)	diagnose, or otherwis Select or discharge h Approve or disapprove medication; Direct the provision,	ght to: consent to any care, treatment, service, se affect a physical or mental condition; nealth care providers and institutions; we diagnostic tests, surgical procedures a withholding, or withdrawal of artificial nursely alth care, including cardiopulmonary resu	and programs of utrition and hydration and
	(date)	(name)	(signature)
autl		Authority : My agent is authorized to maddirect disposition of my remains, excep	
	(date)	(name)	(signature)
(6)	I do not designate ar	ny individual as my agent to make health	n care decisions for me.
	(date)	(name)	(signature)
If vo	u do not want to desig	inate any individual as your agent to make	e any health care decision

If you do not want to designate any individual as your agent to make any health care decision for you, you may cross out sections (1), (2), (3), (4) and (5).

(7) **Nomination of Conservator**: If a conservator 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 conservator, I nominate the alternate agents whom I have named, in the order designated.

第二部份:醫療照護指示

如果下列陳述最能表達您的意願,請在每一項的下面正楷填寫您的姓名、日期及親筆簽名。您可以更改文字中的用句。

如果我無法自己做醫療決定,並填寫書面同意書時,我指示我的醫護人員和相關家屬友人照下列我所陳述的意願執行:

只能選擇第(8) 項或第(9) 項中的一者

(8) 選擇要延長生命: 我希望延長我的生命,即使(1)我的疾病無法治癒,而且病況無法好轉,在相當短的時日內,我將因此死亡,(2)我的意識不清,醫學上合理地確定我的意識無法再恢復,或(3)治療所可能承受的危險和負擔,超過期望的療效。

(您的簽名)	(日期)
或	

(9)選擇不要延長生命:我不希望延長我的生命,如果(1)我的疾病無法治癒,而且病況無法好轉,在相當短的時日內,我將因此死亡,(2)我的意識不清,醫學上合理地確定我的意識無法再恢復,或(3)治療所可能承受的危險和負擔,超過期望的療效。

(您的簽名)	(日期)

我不僅請求並且要求我的家人、朋友、醫師、其他照顧人員、和醫護機構遵從 我下列的指示:

(10) **食物和液體**:如果我無法安全吞嚥,我不希望經由,靜脈點滴或口、鼻、 胃或腸道插管灌食的人工方式,獲得食物或液體以延長我的生命。我希望 獲得適當的藥物減除我的不舒服。如果無法經由正常的給予方式提供我的 營養,我選擇死亡。

(11)感染: 我繼續接受的唯一治療是,減除因感染而造成的疼痛。除非造成疼痛,否則感染本身雖可能導致死亡,就聽其自然,而不要治療。

Part 2: INSTRUCTIONS FOR HEALTH CARE

If the following statements reflect your wishes regarding life-support measures, please sign and date it. You may strike any wording you do not want.

When I become unable to speak for myself and write instructions about my medical care, I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have marked below:

Choose	(8)	or ((9)):
--------	-----	------	-----	----

(8) Choice To Prolong Life: I incurable and irreversible conditions short time, (2) I become unconscill will not regain consciousness, or outweigh the expected benefits. The accepted health care standards.	on that will result in ous and, to a reason r (3) the likely risks	my death within onable degree o and burdens of	a relatively f medical certainty, treatment would
	(your signature)	(date)
	OR		
(9) Choice NOT To Prolong Lift an incurable and irreversible conditime, (2) I become unconscious a not regain consciousness, or (3) the outweigh the expected benefits.	ition that will result nd, to a reasonable	in my death with e degree of med	in a relatively short lical certainty, I will
	(your signature)	(date)
I not only request but demand that the family, friends, physicians, other care- (10) Food and Fluids : If I am unable life by the administration of food or fluids tubes through mouth, nose, stomacy discomfort caused as a result. It is in the normal manner.	givers, and health e to swallow safely ids by any artificial ch or intestines. I v is my wish to die if	care institutions The control of th	p prolong my by needle nor medication for
	(your signature)	(date)	
(11) Infection : The only treatment Infection likely to prove fatal should be and discomfort.	nt I will accept for in left to run its cours	-	_
	(your signature)	(date)	

	·	我認為這樣的急救是	• • • • • • • • • • • • • • • • • • • •	醫院接受手術或做其
			(您的簽名)	(日期)
	* =	戈希望在疾病狀況惡(儘早在適當時間提供		能真實評估我的健康 擇。
			(您的簽名)	(日期)
, , ,	, ,	除了我在下面空欄的治療應該提供給我		• • •
			(您的簽名)	(日期)
神下施 (15)其 或	智能力無法再 ,而不要接受 ,包括:人工 他意願:()	恢復,或恢復的可能 延長生命的各項醫 心肺復甦術、人工。 如果您不同意上述的 述的意願外,您希望。	能性很少時,我 療措施。我特別 呼吸器 、血液透 任何一項,希望	寫下自己的意願時,
		(如果需要更多空白	處填寫,請另加紙張)	
	(日期)	(正楷書寫您的名字)		(您的簽名)
(16)我 的名	·	頁的意願說明書。 簽醫療照護事前指示		事前指示內。每頁我
			(您的簽名)	(日期)

pain and suffering, b	sive Care: I demand the demandary of the second results of the sec	erred to the hospital	for surgery or oth	er
		(your signature)		date)
	e: I want hospice cone course of my illnesseir prognosis - their e		neans that my phy	ysician(s)
	_	(your signature)		date)
narcotics and/or other depress respiration of	Pain: I want caring and treatments to control or might hasten my depration of the needs of	ol pain and other sufeath. My concerns a	fering even if they	y might
		(your signature)	(date)
and if the best availal condition is reversible events without benefinterventions includir resuscitation (CPR),	e that if I am unable to be medical opinion is e or will improve substit of life-prolonging mag, but not limited to: pacemaker, transfusion (If you do not agree you wish to add to the	that there is little or retantially, it is my wish edical intervention. dialysis, respirator/version.	no likelihood that in to die in the norm I specifically do n entilator, cardiopu nal choices above	my illness or nal course of ot want ulmonary
	(add add	ditional sheets if needed)		
(date)	(your name)		(signature)	
` '	pages to my ach page was the sa			
		(your signature)		date)

第三部份: 遺體器官捐贈(自由填寫)

(17)我希望死後,(請在 的部份)	左您希望的項目上,簽 您	医的姓名首等	字母,並劃除不要
() (a) 我捐贈任何 () (b) 我只捐贈下 (c) 我捐贈器官	需要的器官、組織、或 列的器官、組織、或部 組織的目的是為了:	份身體:	
• • • • • • • • • • • • • • • • • • • •	組織移植 ()治療 何器官、組織、或部份		乞 ()教育
(日期)	(正楷書寫姓名)		(簽名)
第四部份: 主治醫師(自由填寫)		
(18) 我指定下列醫師	為我的主治醫師:		
(醫師姓名)			作電話)
(地址)	(城市)	(州)	(郵遞區號)
第五部份:簽名和見證	手續		
(19) 影印本的效力:	這份表格的影印本與正	本具有相同	效力。
(20) 授權人簽名:請在	表格的此欄填寫您的姓	名、地址、	簽名和日期:
(日期)	(授權人正楷姓名)	({	授權人簽名)
(地址)	(城市)	(州)	(郵遞區號)
(21) 見證手續: 除非	:完成下列手續否則這份	醫療照護事	前指示所做的醫護

(21) **見證手續**: 除非完成下列手續否則這份醫療照護事前指示所做的醫護決定將不具有效力:(a)您簽署這份文件時,有兩位您本人認識的合法成人在現場見證,或他們認識您的簽名;或(b)在公證人面前的公證。

如果您是療養院的病人,人權維護者或病人權益保護者必須在見證人聲明上簽名,而且也必須在下述"人權維護者或病人權益保護者聲明"上簽名。

Part 3: DONATION OF ORGANS AT DEATH (optional)

(17)	Upon my death: (in	nitial applicable box and strike any o	f the following you do not want)
() (b) I give the fo (c) My gift is for () Transp	eeded organs, tissues, or parts llowing organs, tissues, or parts on the following purposes: plant () Therapy () Resea nt to give any organs, tissues or par	arch () Education
_	(date)	(printed name)	(signature)
	: PRIMARY PHYSIC	CIAN (optional) Dowing physician as my primary phys	sician:
_	(name of	f physician)	(work phone number)
	(address)	(city)	(state) (zip code)
Part 5:	: WITNESS AND S	IGNATURE	
(19)	Effect of Copy: A	copy of this form has the same effe	ct as the original.
(20)	Signature: Sign an	nd date the form here:	
_	(date)	(printed name)	(signature)
	(address)	(city)	(state) (zip code)

(21) **Witnessing**: This advance health care directive will not be valid for making health care decisions unless it is either: (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public.

If you are a patient in a skilled nursing facility, a patient advocate or ombudsman must sign the Statement of Witnesses and must also sign the Statement of Patient Advocate or Ombudsman declaration.

第一種方式: 見證

"我在加州法律作偽證受懲罰之規定下宣誓(1)我認識簽署或承認此份醫療 照護事前指示文件的人,或經由可靠的證據*,我證明此人的身份;(2)此人在 我的面前簽署或承認此份醫療照護事前指示;(3)此人心智良好,沒有被強逼, 被欺騙或受人影響;(4)我不是此份醫療照護事前指示中指定的代理人;(5)我 不是此人的醫療照護人員,或此人就醫門診或醫院的僱員,我也不是社區老人 療養院或安養院的僱主或僱員。"

第一見證人:

(見證人正楷姓名)	(見證人簽名)		(日期)
(地址)	(城市)	(州)	(郵遞區號)
二見證人:			
(見證人正楷姓名)	 (見證人簽名)		(日期)
(九壁/(五相)	, - , , , , , , , , , , , , , , , , , ,		

附加證詞

至少有一位證人必須在下列陳述後簽名

"在加州法律作偽證受懲罰之規定下,我更進一步宣誓:我和簽署此份 醫療照護事前指示文件的人沒有血親、姻親或領養關係,而且就我所知道,根 據此人現存或由法律執行的遺書裏,我沒有資格繼承此人的任何遺產。"

(見證人正楷姓名)	(見證人簽名)		(日期)
(地址)	(城市)	(州)	(郵遞區號)

人權維護者或病人權益保護者聲明

"我在加州法律作偽證受懲罰規定下宣誓:我是加州耆老處指定的人權維護者或病人權益保護者,依遺囑認證法規第4675條的規定做見證人。"

(見證人正楷姓名)	(見證人簽名)		(日期)
(地址)	(城市)	(州)	(郵遞區號)

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 agent by this health care directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, 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."

First Witness:			
(printed name of witness)	(signature	(date)	
(address)	(city)	(state)	(zip code)
Second Witness:			
(printed name of witness)	(signature	of witness)	(date)
(address)	(city)	(state)	(zip code)
the individual executing this advance and, to the best of my knowledge, I ar his or her death under a will now exis	n not entitled to any par ting or by operation of I	t of the individual's aw."	s estate upon
(printed name of witness)	(signature	of witness)	(date)
(address)	(city)	(state)	(zip code)
Statement of Patient Advocate or C "I declare under penalty of perjury undombudsman as designated by the State witness as required by section 4675 of the section (printed name of witness)	ler the laws of California ate Department of Agin	g and that I am se	
· ,		·	· ,
(address)	(city)	(state)	(zip code)

第二種方式:公證

加州		
於	_(年、月、日),	
在我	(寫上公證人的名字和頭銜)	的面前,
確實(或有可信的證據記意願訂立此授權書。	(寫上授權人的名字) 登明)是授權人本人,並已向:	我證明授權是依自己的
在此蓋章和手印證明		
(公證人簽名)		公證印章
人權維護者或病人權益	益保護者聲明	
	證受懲罰規定下宣誓:我是 依遺囑認證法規第4675條的	加州耆老處指定的人權維護 的規定做見證人。"
(見證人正楷姓名)	(見證人簽名)	(日期)
(地址)	(城市)	(州) (郵遞區號)

*法律允許下列證件均可作為有效的身份證明:加州駕駛執照或身份證、現有或過去五年內領取的美國護照,或以下任何五年內頒發的、具有本人照片及描述、有本人簽名和證件號碼的証件:具有美國移民局蓋章的外國護照、外州或加拿大、墨西哥官方機構發給的駕駛執照、外州或任何美國軍方分支機關簽發的證明卡、受監管下的犯人,應有管教部頒發的犯人身份證明卡。如果授權人是療養院的病人,人權維護者或病人權益保護者可以信任病人家屬、療養院僱主或僱員的代表,只要他們能提供授權人身份的合理證據,可為病人作身份證明。

Alternative No. 2: Notary Public

State of California

CERTIFICATE OF ACKNOWLEDGMENT

County of)							
On	,							
before me,								
	and title of officer) (name of signer)							
who proved to me on the basis of satisfa is/are subscribed to the within instrumer executed the same in his/her/their authors.	who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s)							
•	I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.							
WITNESS my hand and official seal.								
(signature of Notary Public)		NOTARY SEAI	L					
Statement of Patient Advocate or Om	ıbudsman							
"I declare under penalty of perjury under or ombudsman as designated by the Sta witness as required by section 4675 of t	ate Department of A							
(printed name of witness)	(signature	e of witness)	(date)					
(address)	(city)	(state)	(zip code)					

^{*} The law allows one or more of the following forms of identification as convincing evidence of identity: a California driver's license or identification card or U.S. passport that is current or has been issued within five years, contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number; a foreign passport that has been stamped by the U.S. Immigration and Naturalization Service; a driver's license issued by another state or by an authorized Canadian or Mexican agency; or an identification card issued by another state or by any branch of the U.S. armed forces. If the principal is a patient in a skilled nursing facility, a patient advocate or ombudsman may rely on the representations of family members or the administrator or staff of the facility as convincing evidence of identity if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.