

Advance Health Care Directive

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be 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 employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

1. consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition
2. select or discharge health care providers and institutions
3. approve or disapprove diagnostic tests, surgical procedures, and programs of medication
4. direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation, and
5. make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Advance Health Care Directive

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. 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 also provided for you to add to the choices you have made or for you to express any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end.

The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this Advance Health Care Directive or replace this form at any time.

Part 1. Power of Attorney for Health Care Designation of Agent

I, Cory Jack Fryling, appoint my Sister, Cindy Lee Books, as my agent. If Cindy Lee Books cannot serve, I appoint my Sister, Jacquelin Kay Stevens, as my agent. If Cindy Lee Books and Jacquelin Kay Stevens cannot serve, I appoint my Friend, Scott Li-Ju Huang, as my agent.

Any person I have named as my agent will serve unless any of the following conditions occur:

- I revoke his or her authority

Advance Health Care Directive

- he or she becomes unavailable or unwilling to act as my agent, or
- he or she is my spouse or registered domestic partner and we commence proceedings for dissolution, annulment, or termination of the marriage or registered domestic partnership.

Please see **Information for Caregivers and Survivors** for current contact information of the people listed above.

Agent's Authority

Unless I have specified otherwise in this document, I grant my agent full authority on all matters relating to my health care, including full power to give or refuse consent to all medical, surgical, hospital, and related health care.

X _____ By initialing this paragraph, I expressly authorize my agent to make decisions to withhold or withdraw life-prolonging treatment, which would allow me to die, and I acknowledge such decisions could or would allow my death.

X _____ By initialing this paragraph, I expressly authorize my agent to make decisions to withhold or withdraw artificially administered food and water, which would allow me to die, and I acknowledge such decisions could or would allow my death.

My agent's power includes, but is not limited to, the authority to:

- hire and fire medical personnel
- visit me in any hospital, hospice, nursing home, adult home, or other medical care facility
- in accordance with the Health Insurance Portability and Accountability Act, and as my personal representative, request, receive, and review any information, verbal or written, regarding my physical or mental health, including medical and hospital records and other protected health information, and to execute any releases or other documents that may be required in order to obtain such information
- in accordance with any other instructions I give in this document, sign any documents required to request, withdraw, or refuse medical treatment or to be

Advance Health Care Directive

released or transferred to or from a hospital, hospice, nursing home, adult home, or other medical care facility

- authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility, and to execute any releases or other documents that may be required to do so
- choose where I live and receive care and support when those choices relate to my health care needs
- sign any waiver or release from liability required by a hospital or physician, and
- contract on my behalf for any health care related service or facility, without incurring personal financial liability for such contracts.

When Effective

The authority of my agent is effective when my primary physician or another authorized health care provider determines I am incapable of making informed decisions regarding my health care. However, when this document is signed, each individual identified as my agent is, in accordance with the Health Insurance Portability and Accountability Act, my personal representative for all purposes related to any assessment of my capacity to make informed decisions regarding my health care.

Agent's Obligation

My agent shall make decisions for me in accordance with any instructions I give in this document and any other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

Agent's Post-Death Authority

The authority of my agent shall continue after my death for a period of time sufficient for my agent to carry out any wishes described in this section:

- I authorize my agent to donate my organs, tissues, or other body parts according to the instructions set forth in this document.

Advance Health Care Directive

- I authorize my agent to decide whether or not to direct or consent to an autopsy after I die.
- I authorize my agent to direct the disposition of my remains after I die.

Nomination of Conservator

If a court must appoint a conservator of my person, I nominate the agent designated in this form to serve without bond or security. If that agent is not willing, able, or reasonably available to act as conservator, I nominate each alternate agent whom I have named, in the order designated, to serve without bond or security.

Part 2. Instructions for Health Care End-of-Life Decisions

I do **not** want my life to be prolonged if:

- I have a terminal condition
- I am permanently unconscious, or
- The likely risks and burdens of treatment would outweigh the expected benefits.

In accordance with these wishes, I do not want artificially administered food and water.

Grant of Discretion to Agent

If I have expressed, in this document or in any other manner, a clear wish regarding a specific treatment or condition, I want that wish to be followed. In all other situations, I direct that my life not be prolonged and that life-prolonging treatment not be provided or continued, in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall weight the burdens of treatment against the expected benefits, considering my personal values to the extent known to my agent.

Relief From Pain

I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

Other Wishes

In addition to the instructions I have given above, I would also like my health care providers and others involved in my care to follow the instructions below.

Wishes regarding hospitalization and the location of my care

I prefer to receive end-of-life care at home.

Part 3. Donation of Organs at Death

Upon my death, I donate any needed organs, tissues, or other body parts for any purpose allowed under applicable law.

Part 4. Primary Physician

I have historically changed primary physicians on a relatively frequent basis. As such, I am not specifying in this document the physician to be considered my primary physician.

(As of the signing of this document, my current primary physician is Jeff Unger MD, but that may change by the time this directive becomes effective.)

I direct my agent to designate my primary physician based on the available information regarding my current primary physician. In the event my agent cannot ascertain, after reasonable research, my then-current primary physician, or in the event that my agent determines a change of primary physician to be in my best interest, I authorize my agent to select a new physician to act as my primary physician, giving due consideration to my needs, preferences, and values to the extent the agent is aware of them.

Part 5. Definitions

For purposes of this document:

- **Health care** means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.
- **Terminal condition** means a condition that will cause imminent death or, to a reasonable degree of medical certainty, is hopeless unless artificially supported

Advance Health Care Directive

through the use of life-prolonging procedures. The condition must be confirmed by a physician who is qualified and experienced in making such a diagnosis.

- **Permanently unconscious** means a condition that, to a reasonable degree of medical certainty, will last permanently, without improvement, and in which there is no cognitive thought, sensation, purposeful action, social interaction, and awareness of self and environment. In addition, the condition must have existed for a period of time sufficient to make such a diagnosis, and must be confirmed by a physician who is qualified and experienced in making such a diagnosis.
- **Life-prolonging treatment** means any medical treatment, procedure, or intervention that, in the judgment of the attending physicians, would serve only to prolong the dying process where the patient has a terminal illness or injury, or would serve only to maintain the patient in a condition of permanent unconsciousness. These procedures include assisted ventilation, cardiopulmonary resuscitation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs and antibiotics.
- **Artificially administered food and water**—also called nutrition and hydration—means administering food and water through a tube or intravenous line, where the recipient is not required to chew or swallow voluntarily.

Signatures

Governing Law

I intend this document to be my Advance Health Care Directive under California law. However, if any of my health care instructions go beyond what California authorizes, I request that those instructions be respected and followed in keeping with my right to direct my own health care as guaranteed by the U.S. Constitution.

Effect of Copy

A copy of this document has the same effect as the original.

Severability

If a court finds any of the specific provisions in this document to be invalid, that shall not affect other provisions that can be given effect without the invalid provision.

Advance Health Care Directive

Signature

Sign your name: [Signature]

Print your name: Rory Fryling

Address: 955 N. Duesenberg Dr., Apt 5303

City, State: Ontario, CA

Date: 6/7/2021

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 Health Care 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 Advance 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

Sign your name: [Signature]

Print your name: SEAN CASTALON

Address: 955 N. DUESENBERG DR #5303

City, State: ONTARIO CA 91704

Advance Health Care Directive

Date: 6/3/2021

Second Witness

Sign your name: [Signature]

Print your name: Jason Brown

Address: 7978 Sauterne Drive

City, State: Rancho Cucamonga, CA 91730

Date: June 3, 2021

Additional Statement of Witnesses

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this Advance Health Care Directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Signature of witness: [Signature]

Signature of witness: [Signature]

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of San Bernardino)

On June 07, 2021 before me, Taylor Diana Anhaeuser, Notary Public
(insert name and title of the officer)

personally appeared Cory Jack Fryling
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) acted, executed the instrument.

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  (Seal)

