

Requested by SENATE COMMITTEE ON JUDICIARY

**PROPOSED AMENDMENTS TO  
SENATE BILL 494**

1 On page 2 of the printed bill, delete lines 12 through 19 and insert:

2 “(I) One member from among members proposed by the Oregon State Bar  
3 who has extensive experience in elder law and advising individuals on how  
4 to execute an advance directive.

5 “(J) One member from among members proposed by the Oregon State Bar  
6 who has extensive experience in estate planning and advising individuals on  
7 how to make end-of-life decisions.

8 “(K) One member from among members proposed by the Oregon State Bar  
9 who has extensive experience in health law.”.

10 On page 3, line 7, delete “appointing” and insert “appointment of”.

11 After line 8, insert:

12 “(B) A statement about the priority of health care representative ap-  
13 pointment in ORS 127.655 in the event the principal becomes incapable and  
14 does not have a valid health care representative appointment.”.

15 In line 9, delete “(B)” and insert “(C)” and delete “expressing” and insert  
16 “expression of”.

17 In line 11, delete “(C)” and insert “(D)” and delete “expressing” and insert  
18 “expression of”.

19 Delete lines 13 and 14 and insert:

20 “(E) A statement that advises the principal that the advance directive  
21 allows the principal to document the principal’s preferences, but is not a

1 POLST, as defined in ORS 127.663.”.

2 In line 45, delete “(4)” and insert “(4)(a)”.

3 On page 4, line 1, after “language” delete the period and insert: “, such  
4 as ‘tube feeding’ and ‘life support.’

5 “(b) As used in this subsection:

6 “(A) ‘Life support’ means life-sustaining procedures.

7 “(B) ‘Tube feeding’ means artificially administered nutrition and hy-  
8 dration.”.

9 Delete lines 32 through 45 and delete pages 5 through 8 and insert:

10 **“SECTION 5. A form for appointing a health care representative  
11 and an alternate health care representative must be written in sub-  
12 stantially the following form:**

13 “

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14 **FORM FOR APPOINTING HEALTH CARE REPRESENTATIVE**  
15 **AND ALTERNATE HEALTH CARE REPRESENTATIVE**

16

17 **This form may be used in Oregon to choose a person to make health  
18 care decisions for you if you become too sick to speak for yourself.  
19 The person is called a health care representative.**

20 • **If you have completed a form appointing a health care represen-  
21 tative in the past, this new form will replace any older form.**

22 • **You must sign this form for it to be effective. You must also have  
23 it witnessed by two witnesses or a notary. Your appointment of a  
24 health care representative is not effective until the health care repre-  
25 sentative accepts the appointment.**

26 • **If you become too sick to speak for yourself and do not have an  
27 effective health care representative appointment, a health care repre-  
28 sentative will be appointed for you in the order of priority set forth in  
29 ORS 127.635 (2).**

30 **1. ABOUT ME.**

1     **Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
2     **Telephone numbers: (Home)**\_\_\_\_\_ **(Work)**\_\_\_\_\_ **(Cell)**\_\_\_\_\_  
3     **Address:** \_\_\_\_\_  
4     **E-mail:** \_\_\_\_\_

5     **2. MY HEALTH CARE REPRESENTATIVE.**

6     **I choose the following person as my health care representative to**  
7 **make health care decisions for me if I can't speak for myself.**

8     **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
9     **Telephone numbers: (Home)**\_\_\_\_\_ **(Work)**\_\_\_\_\_ **(Cell)**\_\_\_\_\_  
10    **Address:** \_\_\_\_\_  
11    **E-mail:** \_\_\_\_\_

12    **I choose the following people to be my alternate health care repre-**  
13 **sentatives if my first choice is not available to make health care de-**  
14 **isions for me or if I cancel the first health care representative's**  
15 **appointment.**

16    **First alternate health care representative:**

17    **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
18    **Telephone numbers: (Home)**\_\_\_\_\_ **(Work)**\_\_\_\_\_ **(Cell)**\_\_\_\_\_  
19    **Address:** \_\_\_\_\_  
20    **E-mail:** \_\_\_\_\_

21    **Second alternate health care representative:**

22    **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
23    **Telephone numbers: (Home)**\_\_\_\_\_ **(Work)**\_\_\_\_\_ **(Cell)**\_\_\_\_\_  
24    **Address:** \_\_\_\_\_  
25    **E-mail:** \_\_\_\_\_

26    **3. MY SIGNATURE.**

27    **My signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

28    **4. WITNESS.**

29    **COMPLETE A OR B WHEN YOU SIGN.**

30    **A. WITNESS DECLARATION:**

1 The person completing this form is personally known to me or has  
2 provided proof of identity, has signed or acknowledged the person's  
3 signature on the document in my presence and appears to be not under  
4 duress and to understand the purpose and effect of this form. In ad-  
5 dition, I am not the person's health care representative or alternate  
6 health care representative, and I am not the person's attending health  
7 care provider.

8 Witness Name (print): \_\_\_\_\_

9 Signature: \_\_\_\_\_

10 Date: \_\_\_\_\_

11 Witness Name (print): \_\_\_\_\_

12 Signature: \_\_\_\_\_

13 Date: \_\_\_\_\_

14 **B. NOTARY:**

15 State of \_\_\_\_\_

16 County of \_\_\_\_\_

17 Signed or attested before me on \_\_\_\_\_, 2\_\_\_\_, by  
18 \_\_\_\_\_.

19 \_\_\_\_\_

20 Notary Public - State of Oregon

21 **5. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.**

22 I accept this appointment and agree to serve as health care repre-  
23 sentative.

24 Health care representative:

25 Printed name: \_\_\_\_\_

26 Signature or other verification of acceptance: \_\_\_\_\_

27 Date \_\_\_\_\_

28 First alternate health care representative:

29 Printed name: \_\_\_\_\_

30 Signature or other verification of acceptance: \_\_\_\_\_

1     **Date \_\_\_\_\_**  
2     **Second alternate health care representative:**  
3     **Printed name: \_\_\_\_\_**  
4     **Signature or other verification of acceptance: \_\_\_\_\_**  
5     **Date \_\_\_\_\_**  
6     “ \_\_\_\_\_

7  
8                   **(Temporary Form for Advance Directive)**  
9

10     **“SECTION 6. (1) In lieu of the form of an advance directive adopted**  
11 **by the Advance Directive Rules Adoption Committee under section 3**  
12 **of this 2017 Act, on or before January 1, 2021, a principal may execute**  
13 **an advance directive that is in a form that is substantially the same**  
14 **as the form of an advance directive set forth in this section.**

15     **“(2) Notwithstanding section 3 (2) of this 2017 Act, the form of an**  
16 **advance directive set forth in this section is a valid form of an advance**  
17 **directive in this state.**

18     **“(3) The form of an advance directive executed as described in**  
19 **subsection (1) of this section is as follows:**

20     “ \_\_\_\_\_  
21                                   **ADVANCE DIRECTIVE**  
22                                   **(STATE OF OREGON)**  
23

24     **This form may be used in Oregon to choose a person to make health**  
25 **care decisions for you if you become too sick to speak for yourself.**  
26 **The person is called a health care representative. If you do not have**  
27 **an effective health care representative appointment and become too**  
28 **sick to speak for yourself, a health care representative will be ap-**  
29 **pointed for you in the order of priority set forth in ORS 127.635 (2).**

30     **This form also allows you to express your values and beliefs with**

1 respect to health care decisions and your preferences for health care.

2 • If you have completed an advance directive in the past, this new  
3 advance directive will replace any older directive.

4 • You must sign this form for it to be effective. You must also have  
5 it witnessed by two witnesses or a notary. Your appointment of a  
6 health care representative is not effective until the health care repre-  
7 sentative accepts the appointment.

8 • If your advance directive includes directions regarding the with-  
9 drawal of life support or tube feeding, you may revoke your advance  
10 directive at any time and in any manner that expresses your desire to  
11 revoke it.

12 • In all other cases, you may revoke your advance directive at any  
13 time and in any manner as long as you are capable of making medical  
14 decisions.

15 **1. ABOUT ME.**

16 **Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

17 **Telephone numbers: (Home)**\_\_\_\_\_ **(Work)**\_\_\_\_\_ **(Cell)**\_\_\_\_\_

18 **Address:** \_\_\_\_\_

19 **E-mail:** \_\_\_\_\_

20 **2. MY HEALTH CARE REPRESENTATIVE.**

21 I choose the following person as my health care representative to  
22 make health care decisions for me if I can't speak for myself.

23 **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

24 **Telephone numbers: (Home)**\_\_\_\_\_ **(Work)**\_\_\_\_\_ **(Cell)**\_\_\_\_\_

25 **Address:** \_\_\_\_\_

26 **E-mail:** \_\_\_\_\_

27 I choose the following people to be my alternate health care repre-  
28 sentatives if my first choice is not available to make health care de-  
29 cisions for me or if I cancel the first health care representative's  
30 appointment.

1 **First alternate health care representative:**

2 **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

3 **Telephone numbers: (Home)**\_\_\_\_\_ **(Work)**\_\_\_\_\_ **(Cell)**\_\_\_\_\_

4 **Address:** \_\_\_\_\_

5 **E-mail:** \_\_\_\_\_

6 **Second alternate health care representative:**

7 **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

8 **Telephone numbers: (Home)**\_\_\_\_\_ **(Work)**\_\_\_\_\_ **(Cell)**\_\_\_\_\_

9 **Address:** \_\_\_\_\_

10 **E-mail:** \_\_\_\_\_

11 **3. INSTRUCTIONS TO MY HEALTH CARE REPRESENTATIVE.**

12 **If you wish to give instructions to your health care representative**  
13 **about your health care decisions, initial one of the following three**  
14 **statements:**

15 **\_\_\_ To the extent appropriate, my health care representative must**  
16 **follow my instructions.**

17 **\_\_\_ My instructions are guidelines for my health care representative**  
18 **to consider when making decisions about my care.**

19 **\_\_\_ Other instructions:** \_\_\_\_\_

20 **4. DIRECTIONS REGARDING MY END OF LIFE CARE.**

21 **In filling out these directions, keep the following in mind:**

22 **• The term “as my health care provider recommends” means that**  
23 **you want your health care provider to use life support if your health**  
24 **care provider believes it could be helpful, and that you want your**  
25 **health care provider to discontinue life support if your health care**  
26 **provider believes it is not helping your health condition or symptoms.**

27 **• The term “life support” means any medical treatment that**  
28 **maintains life by sustaining, restoring or replacing a vital function.**

29 **• The term “tube feeding” means artificially administered food and**  
30 **water.**

1 • If you refuse tube feeding, you should understand that  
2 malnutrition, dehydration and death will probably result.

3 • You will receive care for your comfort and cleanliness no matter  
4 what choices you make.

5 **A. Statement Regarding End of Life Care.** You may initial the  
6 statement below if you agree with it. If you initial the statement you  
7 may, but you do not have to, list one or more conditions for which you  
8 do not want to receive life support.

9 \_\_\_ I do not want my life to be prolonged by life support. I also do  
10 not want tube feeding as life support. I want my health care provider  
11 to allow me to die naturally if my health care provider and another  
12 knowledgeable health care provider confirm that I am in any of the  
13 medical conditions listed below.

14 **B. Additional Directions Regarding End of Life Care.** Here are my  
15 desires about my health care if my health care provider and another  
16 knowledgeable health care provider confirm that I am in a medical  
17 condition described below:

18 **a. Close to Death.** If I am close to death and life support would only  
19 postpone the moment of my death:

20 **INITIAL ONE:**

21 \_\_\_ I want to receive tube feeding.

22 \_\_\_ I want tube feeding only as my health care provider recom-  
23 mends.

24 \_\_\_ I DO NOT WANT tube feeding.

25 **INITIAL ONE:**

26 \_\_\_ I want any other life support that may apply.

27 \_\_\_ I want life support only as my health care provider recom-  
28 mends.

29 \_\_\_ I DO NOT WANT life support.

30 **b. Permanently Unconscious.** If I am unconscious and it is very

1 **unlikely that I will ever become conscious again:**

2 **INITIAL ONE:**

3  **I want to receive tube feeding.**

4  **I want tube feeding only as my health care provider recom-**  
5 **mends.**

6  **I DO NOT WANT tube feeding.**

7 **INITIAL ONE:**

8  **I want any other life support that may apply.**

9  **I want life support only as my health care provider recom-**  
10 **mends.**

11  **I DO NOT WANT life support.**

12 **c. Advanced Progressive Illness. If I have a progressive illness that**  
13 **will be fatal and is in an advanced stage, and I am consistently and**  
14 **permanently unable to communicate by any means, swallow food and**  
15 **water safely, care for myself and recognize my family and other peo-**  
16 **ple, and it is very unlikely that my condition will substantially im-**  
17 **prove:**

18 **INITIAL ONE:**

19  **I want to receive tube feeding.**

20  **I want tube feeding only as my health care provider recom-**  
21 **mends.**

22  **I DO NOT WANT tube feeding.**

23 **INITIAL ONE:**

24  **I want any other life support that may apply.**

25  **I want life support only as my health care provider recom-**  
26 **mends.**

27  **I DO NOT WANT life support.**

28 **d. Extraordinary Suffering. If life support would not help my med-**  
29 **ical condition and would make me suffer permanent and severe pain:**

30 **INITIAL ONE:**

1     \_\_\_ I want to receive tube feeding.

2     \_\_\_ I want tube feeding only as my health care provider recom-  
3 mends.

4     \_\_\_ I DO NOT WANT tube feeding.

5     **INITIAL ONE:**

6     \_\_\_ I want any other life support that may apply.

7     \_\_\_ I want life support only as my health care provider recom-  
8 mends.

9     \_\_\_ I DO NOT WANT life support.

10    **C. Additional Instruction.** You may attach to this document any  
11 writing or recording of your values and beliefs related to health care  
12 decisions. These attachments will serve as guidelines for health care  
13 providers. Attachments may include a description of what you would  
14 like to happen if you are close to death, if you are permanently un-  
15 conscious, if you have an advanced progressive illness or if you are  
16 suffering permanent and severe pain.

17    **5. MY SIGNATURE.**

18    My signature: \_\_\_\_\_ Date: \_\_\_\_\_

19    **6. WITNESS.**

20    **COMPLETE A OR B WHEN YOU SIGN.**

21    **A. WITNESS DECLARATION:**

22    The person completing this form is personally known to me or has  
23 provided proof of identity, has signed or acknowledged the person's  
24 signature on the document in my presence and appears to be not under  
25 duress and to understand the purpose and effect of this form. In ad-  
26 dition, I am not the person's health care representative or alternate  
27 health care representative, and I am not the person's attending health  
28 care provider.

29    **Witness Name (print):** \_\_\_\_\_

30    **Signature:** \_\_\_\_\_

1 **Date:** \_\_\_\_\_

2 **Witness Name (print):** \_\_\_\_\_

3 **Signature:** \_\_\_\_\_

4 **Date:** \_\_\_\_\_

5 **B. NOTARY:**

6 **State of** \_\_\_\_\_

7 **County of** \_\_\_\_\_

8 **Signed or attested before me on** \_\_\_\_\_, 2\_\_\_\_, **by**

9 \_\_\_\_\_.

10 \_\_\_\_\_

11 **Notary Public - State of Oregon**

12 **7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.**

13 **I accept this appointment and agree to serve as health care repre-**  
14 **sentative.**

15 **Health care representative:**

16 **Printed name:** \_\_\_\_\_

17 **Signature or other verification of acceptance:** \_\_\_\_\_

18 **Date** \_\_\_\_\_

19 **First alternate health care representative:**

20 **Printed name:** \_\_\_\_\_

21 **Signature or other verification of acceptance:** \_\_\_\_\_

22 **Date** \_\_\_\_\_

23 **Second alternate health care representative:**

24 **Printed name:** \_\_\_\_\_

25 **Signature or other verification of acceptance:** \_\_\_\_\_

26 **Date** \_\_\_\_\_

27 “ \_\_\_\_\_ ”.

28 On page 9, delete lines 1 through 41.

29 On page 10, line 14, after “use” delete the rest of the line and insert “an  
30 advance directive or the”.

1 In line 19, after “use” delete the rest of the line and insert “an advance  
2 directive or the form”.

3 On page 12, line 8, delete “validated” and insert “valid”.

4 Delete lines 36 and 37 and insert:

5 “(2)(a) ‘Advance directive’ means a document executed by a principal that  
6 contains:

7 “(A) A form appointing a health care representative; and

8 “(B) Instructions to the health care representative.

9 “(b) ‘Advanced directive’ includes any supplementary document or writing  
10 attached by the principal to the document described in paragraph (a) of this  
11 subsection.”.

12

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