Health Care Durable Power of Attorney

(Alabama Code § 26-1A-404)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint an attorney in fact in case of my incapacity.

2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.

3. **Regarding end-of-life matters:** [initial one of the two choices]

   (a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.

   (b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.

4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

5. I give no one (including my attorney in fact) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.

6. Apart from the matters covered above, I appoint the person named herein as my attorney in fact to make health-care decisions for me. I give my attorney in fact full power and authority to consent to or to refuse treatment (including the providing, withholding, or withdrawing of life-sustaining treatment and artificially provided nutrition and hydration) on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed attorney in fact is unavailable, unable, or unwilling to serve, I appoint an alternate attorney in fact herein to serve with the same power and authority. This Health Care Durable Power of Attorney shall become effective upon my disability, incompetency, or incapacity.

7. THIS DOCUMENT MUST BE SIGNED AND DATED BY THE PRINCIPAL, BY TWO WITNESSES, AND BY THE ATTORNEY IN FACT AND ALTERNATE ATTORNEY IN FACT.

(Signature*) (Date)

(Address)

STATEMENT OF WITNESSES: I am witnessing this Health Care Durable Power of Attorney because I believe the principal (the person who signed above) to be of sound mind. I am 19 years of age or older, and **I am not (1) the attorney in fact or the alternate attorney in fact,** (2) related to the principal by blood, adoption, or marriage, (3) entitled to any part of the principal's estate, (4) directly responsible for paying for the principal's medical care, or (5) the person who signed this document on behalf of and at the direction of the principal.

(Signature of witness / Date) (Signature of witness / Date)

(Address) (Address)

ACCEPTANCE OF ATTORNEY IN FACT APPOINTMENT: I am willing to serve as the principal's attorney in fact or alternate attorney in fact.

(Signature of attorney in fact / Date) (Signature of alternate attorney in fact / Date)

ATTORNEY IN FACT*

Name:

Address:

Telephone(s):

ALTERNATE ATTORNEY IN FACT*

Name:

Address:

Telephone(s):

* **Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your attorneys in fact). You should sign this document in the presence of two witnesses. You may appoint any person 19 years of age or older to be your attorney in fact except (1) your health-care provider or (2) a nonrelative employee of your health-care provider. A "nonrelative" is a person not related to you by blood, marriage, or adoption.

Health Care Durable Power of Attorney
(signed document inside)

NO BLOOD