# Appointment of Health Care Representative

(Connecticut General Statutes §§ 19a-570 to 19a-580g)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care representative 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 <u>one</u> 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 representative) 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 health-care representative to make health-care decisions for me, including the decision to provide, withhold, or withdraw life support systems. I give my representative full power and authority to consent to or to refuse treatment 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 representative is unavailable, unable, or unwilling to serve, I appoint an alternate representative herein to serve with the same power and authority.

7. **Regarding health-care decisions during pregnancy [if applicable]:** I direct that my health-care provider and my health-care representative fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my health-care representative has the authority to make health-care decisions for me even while I am pregnant.

8. These instructions and appointments are made, after careful reflection, while I am of sound mind.

(Signature*) (Date)

(Address)

STATEMENT OF WITNESSES: [Note: If the person who signed this document above resides in a facility operated or licensed by the Department of Mental Health and Addiction Services or the Department of Developmental Services, at least one witness shall be an individual who is not affiliated with the facility and at least one witness shall be a physician or licensed clinical psychologist with specialized training in treating mental illness or developmental disabilities.]

This document was signed in our presence by the above-named author, who appeared to be 18 years of age or older, of sound mind and able to understand the nature and consequences of health-care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other. We are 18 years of age or older. **We are <u>not</u> the health-care representative or alternate representative appointed in this document.**

(Signature of witness) (Signature of witness)

(Address) (Address)

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HEALTH-CARE REPRESENTATIVE*

Name:

Address:

Telephone(s):

ALTERNATE HEALTH-CARE REPRESENTATIVE*

Name:

Address:

Telephone(s):

* **Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your health-care representatives). You should sign this document in the presence of two witnesses. You may appoint any adult to be your representative <u>except</u> (1) your attending physician, (2) a nonrelative operator, administrator, or employee of a hospital, residential care home, rest home with nursing supervision, or chronic and convalescent nursing home where, at the time of the execution of this document, you are a patient, resident, or have applied for admission, or (3) a nonrelative administrator or employee of a government agency that is financially responsible for your medical care. A "nonrelative" is a person who is not related to you by blood, marriage, or adoption.

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**Appointment of Health Care Representative**
(signed document inside)

**NO BLOOD**