Durable Power of Attorney for Health Care

(District of Columbia Code §§ 21-2201 to 21-2213)

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 artificial 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 power of attorney becomes effective upon my incapacity. By my signature below, I indicate that I understand the purpose and effect of this document.

_____ _____

(Signature*) (Date)

_____

(Address)

STATEMENT OF WITNESSES: I declare that the principal (the person who signed on page 1) is personally known to me, that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, and that the principal appears to be of sound mind and free from duress, fraud, or undue influence. **I am not (1) the attorney in fact or alternate attorney in fact appointed in this document,** (2) the principal's health-care provider, or (3) an employee of the principal's health-care provider.

_____ _____

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

_____ _____

(Address) (Address)

AT LEAST ONE OF THE ABOVE WITNESSES SHALL ALSO SIGN THE FOLLOWING DECLARATION: I further declare that I am not related to the principal by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law.

_____ _____

(Signature) (Signature)

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 adult to be your attorney in fact except for your health-care provider.

Durable Power of Attorney for Health Care
(signed document inside)

NO BLOOD