

Advance Directive for Health Care

(Florida Statutes §§ 765.101 to 765.404)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care surrogate 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 surrogate) 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 surrogate to make health-care decisions for me. I give my surrogate full power and authority to consent to or to refuse treatment (including artificial nutrition and hydration) on my behalf, to consult with my doctors, to access my health information, to receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed surrogate is unavailable, unable, or unwilling to serve, I appoint an alternate surrogate 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 surrogate fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my health-care surrogate has the authority to make health-care decisions for me even while I am pregnant.
8. I sign my name to this Advance Directive for Health Care on the date indicated below.

 (Signature*) (Date)

 (Address)

STATEMENT OF WITNESSES: The principal (the person who signed above) signed this document in my presence. He or she appears to be of sound mind and free from duress, fraud, or undue influence. I am 18 years of age or older. **I am not the health-care surrogate or alternate surrogate appointed in this document.** Also, at least one of us is not the principal's spouse or blood relative.

 (Signature of witness) (Signature of witness)

 (Address) (Address)

HEALTH-CARE SURROGATE*

Name: _____

Address: _____

Telephone(s): _____

ALTERNATE HEALTH-CARE SURROGATE*

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 surrogates). You should sign this document in the presence of two witnesses. You may appoint any adult to be your surrogate. However, it is recommended that you not appoint your physician, any of your physician's employees, or any employee of a hospital or nursing home where you might be a patient unless the person you appoint is related to you by blood, marriage, or adoption.

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 (signed document inside)

NO BLOOD

