

Power of Attorney for Health Care

(755 Illinois Compiled Statutes 45/4-1 to 45/4-12)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care agent 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 pre-donate 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 agent) 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 agent to make health-care decisions for me. I give my agent 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 agent is unavailable, unable, or unwilling to serve, I appoint a successor agent herein to serve with the same power and authority. I am fully

informed as to all the contents of this Power of Attorney for Health Care and understand the full import of this grant of powers to my health-care agent.

(Signature*)

(Date)

(Address)

STATEMENT OF WITNESSES: The principal (the person who signed above) signed this document or acknowledged his or her signature or mark on 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 agent or successor agent appointed in this document.** I am not related to the principal, the agent, or the successor agent by blood, marriage, or adoption. I am not the principal's physician, advanced practice nurse, physician assistant, dentist, podiatric physician, optometrist, or psychologist, or a relative of one of those individuals. I am not an owner or operator or the relative of an owner or operator of the health-care facility where the principal is a patient or resident.

(Signature of witness)

(Signature of witness)

(Address)

(Address)

HEALTH-CARE AGENT*

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 agents). You should sign this document in the presence of two witnesses. You may appoint any adult to be your agent except (1) your attending physician, or (2) a health-care provider or a health-care professional administering health care to you.

SUCCESSOR HEALTH-CARE AGENT*

Name: _____

Address: _____

Telephone(s): _____

Power of Attorney for Health Care
(signed document inside)

NO BLOOD

