Appointment of Health Care Representative

(Indiana Code §§ 16-36-1-1 to 16-36-1-14 and § 30-5-5-17)

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 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 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. I give my representative 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 representative is unavailable, unable, or unwilling to serve, I appoint an alternate representative herein to serve with the same power and authority.

7. I authorize my health-care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health-care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health-care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My

health-care representative must try to discuss this decision with me. However, if I am unable to communicate, my health-care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health-care givers. To the extent appropriate, my health-care representative may also discuss this decision with my family and others to the extent they are available.

8. I sign my name to this document on the date indicated below and do hereby declare to the undersigned witnesses that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am of sound mind, and under no constraint or undue influence.

_____ _____
(Signature*) (Date)

_____
(Address)

STATEMENT OF WITNESSES: The person who signed this document above did so 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 <u>not</u> the health-care representative or alternate representative appointed in this document.**

_____ _____
(Signature of witness) (Signature of witness)

_____ _____
(Address) (Address)

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. However, it is recommended that you <u>not</u> 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.

Appointment of Health Care Representative
(signed document inside)

NO BLOOD