Health Care Power of Attorney

(South Carolina Code Annotated §§ 62-5-501 to 62-5-505)

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH-CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.
2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.
3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH-CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.
4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH-CARE PROVIDER ORALLY OR IN WRITING.
5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.
6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR

SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

A. YOUR SPOUSE; YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

D. A BENEFICIARY OF A LIFE INSURANCE POLICY ON YOUR LIFE.

E. THE PERSONS NAMED IN THE HEALTH CARE POWER OF ATTORNEY AS YOUR AGENT OR SUCCESSOR AGENT.

F. YOUR PHYSICIAN OR AN EMPLOYEE OF YOUR PHYSICIAN.

G. ANY PERSON WHO WOULD HAVE A CLAIM AGAINST ANY PORTION OF YOUR ESTATE (PERSONS TO WHOM YOU OWE MONEY).

IF YOU ARE A PATIENT IN A HEALTH FACILITY, NO MORE THAN ONE WITNESS MAY BE AN EMPLOYEE OF THAT FACILITY.

7. YOUR AGENT MUST BE A PERSON WHO IS 18 YEARS OLD OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH-CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

8. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH-CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH-CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

Health Care Power of Attorney

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 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 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 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.

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

8. **Regarding tube feeding and artificial nutrition and hydration:** I authorize my health-care agent to make decisions on my behalf about the providing, withholding, or withdrawing of tube feeding and artificial nutrition and hydration.

   [initial here, if you agree] _____

9. BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.
I sign my name to this Health Care Power of Attorney on the date indicated below.

_____ _____
(Signature*) (Date)

_____
(Address)

STATEMENT OF WITNESSES: I declare, on the basis of information and belief, that the principal (the person who signed or acknowledged this document above) is personally known to me, that he or she signed or acknowledged this Health Care Power of Attorney in my presence, and that he or she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of any policy of insurance on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. **I am <u>not</u> the health-care agent or successor agent appointed in this document.**

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

_____ _____
(Address) (Address)

HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

SUCCESSOR 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 of sound mind to be your agent <u>except</u> (1) your nonrelative health-care provider at the time you execute this document, (2) a nonrelative employee of your health-care provider, (3) a nonrelative employee of the nursing-care facility in which you reside, or (4) the nonrelative spouse of any of the above-mentioned persons. A "nonrelative" is a person who is not related to you by blood, marriage, or adoption.

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(signed document inside)

NO BLOOD