

ADVANCE DIRECTIVE FOR HEALTH CARE

This advance directive for health care is made this ____ day of _____, 2005.

I, **Name of Person, address of person, Florence, Alabama 35630**, being nineteen years of age or older, of sound mind, hereby revoke any prior advance directive for health care, and in lieu thereof, hereby willfully and voluntarily make known my desires by my instructions to others through my living will, or by my appointment of a health care proxy, or both, that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

I. LIVING WILL

If my attending physician determines that I am no longer able to give directions to my health care providers regarding my medical treatment, I direct my attending physician and other health care providers to provide, withhold, or withdraw certain treatment from me under the circumstances I have indicated below by my initials. I understand that by initialing any of the paragraphs in this Living Will I am authorizing the withholding or withdrawal of certain treatments and this may lead to my death. I understand that I will be given treatment that is necessary for comfort or to alleviate my pain except where I specifically request otherwise.

(A) **TERMINAL ILLNESS OR INJURY.** If my attending physician and another physician determine that I have an incurable terminal illness or injury which will lead to my death within six months or less:

(1) I DO want medically indicated life-sustaining treatment even if it will not cure me and will only prolong the dying process.

(Initials)

OR

I do NOT want life sustaining treatment which would not cure me but which would only prolong the dying process.

(Initials)

In addition, before life-sustaining treatment is withheld or withdrawn as directed above, I direct that my attending physician shall discuss with the following persons, if they are available, the benefits and burdens of taking such action and my stated wishes in this advance directive: **Name of person to contact, address of person to contact, Florence, Alabama 35630**, or, if

(s)he is unavailable, **Name of person to contact, address of person to contact, Florence, Alabama 35630.**

(Initials)

(2) I understand that artificially provided nutrition and hydration (tube feeding of food and water) may be necessary to preserve my life.

(i) I DO want medically indicated artificially provided nutrition and hydration, even if it will only prolong the dying process.

(Initials)

OR

(ii) I do NOT want artificially provided nutrition and hydration under the circumstances initialed below:

_____(a) even if withholding or withdrawing it causes me pain.
(Initials)

OR

_____(b) only if withholding it or withdrawing it, in the judgment of
(Initials) my attending physician, would not cause me undue pain.

In addition, before life-sustaining treatment is withheld or withdrawn as directed above, I direct that my attending physician shall discuss with the following persons, if they are available, the benefits and burdens of taking such action and my stated wishes in this advance directive: **Name of person to contact, address of person to contact, Florence, Alabama 35630**, or, if (s)he is unavailable, **Name of person to contact, address of person to contact, Florence, Alabama 35630.**

(Initials)

(3) I direct that (add other medical directives, if any) (if none, state "none"):

(Initials)

(B) PERMANENT UNCONSCIOUSNESS: If, in the judgment of my attending physician and another physician, I am in a condition of permanent unconsciousness:

(1) I DO want medically indicated life-sustaining treatment, even if it will not cure me and will only maintain me in a condition of permanent unconsciousness.

(Initials)

OR

I do NOT want life-sustaining treatment which would not cure me but which would only maintain me in a condition of permanent unconsciousness.

(Initials)

In addition, before life-sustaining treatment is withheld or withdrawn as directed above, I direct that my attending physician shall discuss with the following persons, if they are available, the benefits and burdens of taking such action and my stated wishes in this advance directive: **Name of person to contact, address of person to contact, Florence, Alabama 35630**, or, if (s)he is unavailable, **Name of person to contact, address of person to contact, Florence, Alabama 35630**.

(Initials)

(2) I understand that artificially provided nutrition and hydration (tube feeding of food and water) may be necessary to preserve my life.

(i) I DO want medically indicated artificially provided nutrition, even if it will only maintain me in a condition of permanent unconsciousness.

(Initials)

OR

(ii) I do NOT want artificially provided nutrition and hydration under the circumstances initialed below:

_____ (a) even if withholding or withdrawing it causes me pain.

(Initials)

_____ (b) only if withholding it or withdrawing it, in the judgment of my attending physician, would not cause me undue pain.

(Initials)

In addition, before life-sustaining treatment is withheld or withdrawn as directed above, I direct that my attending physician shall discuss with the following persons, if they are available, the benefits and burdens of taking such action and my stated wishes in this advance directive: **Name of person to contact, address of person to contact, Florence, Alabama 35630**, or, if (s)he is unavailable, **Name of person to contact, address of person to contact, Florence, Alabama 35630**.

(Initials)

(3) I direct that (add other medical directives, if any) (if none, state "none"):

_____.

(Initials)

II. APPOINTMENT OF MY HEALTH CARE PROXY

I understand that my health care proxy is a person whom I may chose here to make medical treatment decisions for me as described below.

I do NOT want to appoint a health care proxy.

(Initials)

OR

I DO want to appoint a healthcare proxy. If my attending physician determines that I am no longer able to direct my healthcare because of my disability, incapacity, or incompetency, I direct my attending physician and other health care providers to follow the instructions of **Name of person, address of person, Florence, Alabama 35630**, whom I appoint as my health care proxy. If said health care proxy is unable to serve, I appoint **Name of alternate appointment, address of person, Florence, Alabama, 35630**, as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, including decisions regarding the withholding or withdrawing of life-sustaining treatment.

(a) This appointment of my health care proxy shall become effective upon my disability, incompetency, or incapacity. My disability, incompetency, or incapacity shall be defined as a physical or mental condition, which renders me incapable of giving directions to my health care providers regarding my medical treatment, as determined by the sole opinion of my attending physician. If or when I recover from any disability, incompetency, or incapacity which activated this power of attorney the powers granted hereby shall be terminated, until such time as my attending physician again determines that I suffer from disability, incompetency or incapacity. The determination as to whether or not I have recovered from my disability, incompetency, or incapacity shall be made by and within the sole discretion of my attending physician.

(b) Durable Power of Attorney. I intend this appointment to be the creation of a

durable power of attorney under the Alabama Durable Power of Attorney Act, Section 26-1-2, Code of Alabama, 1975, as the same should be amended from time to time, for my health care proxy to make the decisions set forth above and to become effective upon my attending physician's determination that I am no longer able to direct my health care because of my disability, incapacity, or incompetency.

(c) My health care proxy is authorized, subject to the provisions of Section II.2. (e) and (f) below, to make whatever medical treatment decisions I could make if I were able, including without limitation, decisions regarding the giving or withholding or withdrawing of life-sustaining procedures, health treatment, medical procedures, health procedures, health care, or diagnostic procedures, to talk with health care personnel, obtain information and sign forms necessary to carry out such decisions, as well as to execute authorizations for medical treatment and for the administration of drugs, therapy, testing, radiological testing, anesthetic drugs and devices, surgery, cosmetic surgery, reconstructive surgery, blood transfusions, and in general for any type of medical treatment administered by any practitioner of the healing arts (including but without limitation, medical doctors, registered nurses, licensed practical nurses, therapists, allied health professionals, home health agencies, psychiatric doctors and psychologists) and to do all such acts and things as fully and effectually in all respects, and to all of the same intents and purposes, as I myself could do by my own hand, or in my own person, if present and acting.

(d) I direct my health proxy to make decisions regarding my health care to conform as closely as possible to what I would have done or intended under the circumstances, taking into account my personal, philosophical, religious and moral beliefs, and ethical values relative to such decisions. Where possible, my health proxy shall determine how I would have weighed the burdens and benefits of withholding or withdrawing life-sustaining treatments or artificially provided nutrition and hydration against the benefits and burdens to me of such treatment. Before life-sustaining treatment or artificially-provided nutrition or hydration is withdrawn or withheld, I direct my health proxy to consult with my attending physician concerning the benefits and burdens of such action and, if available, my remaining immediate family (my spouse, my parents, and my adult children).

(e) I specifically do (____) do not (____) authorize my health care proxy to make decisions regarding whether artificially provided nutrition and hydration be withheld or withdrawn.

(Initials)

(f) I specifically direct my health care proxy to (add other medical directives, if any) (if none, state "none"):

_____.

(Initials)

III. CONFLICTING PROVISIONS

If the decisions made by the person I have appointed as my health care proxy disagree with the instructions in my Living Will:

(Initials) I want the instructions in my Living Will to be followed.

OR

(Initials) I want the person I have appointed as health care proxy to make the final decision

IV. DEFINITIONS

As used in this advance directive, for health care, the following terms have the meaning set forth below:

(A) **ARTIFICIALLY PROVIDED NUTRITION AND HYDRATION.** A medical treatment consisting of the administration of food and water through a tube or intravenous line, where I am not required to chew or swallow voluntarily. Artificially provided nutrition and hydration does not include assisted feeding, such as spoon or bottle feeding.

(B) **LIFE-SUSTAINING TREATMENT.** Any medical treatment procedure, or intervention, that, in the judgment of the attending physician, when applied to me, would serve only to prolong the dying process where I have a terminal illness or injury, or would serve only to maintain me in a condition of permanent unconsciousness. These procedures shall include, but are not limited to, assisted ventilation, cardiopulmonary resuscitation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs and antibiotics. Life-sustaining treatment shall not include the administration of medication or the performance of any medical treatment, where, in the opinion of the attending physician, the medication or treatment is necessary to provide comfort or to alleviate pain.

(C) **PERMANENT UNCONSCIOUSNESS.** A condition that, to a reasonable degree of medical certainty:

1. Will last permanently, without improvement; and
2. In which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent; and

3. Which condition has existed for a period of time sufficient, in accordance with applicable professional standards, to make such a diagnosis; and

4. Which condition is confirmed by a physician who is qualified and experienced in making such a diagnosis.

(D) **TERMINALLY ILL OR INJURED PATIENT.** A patient whose death is imminent or whose condition, to a reasonable degree of medical certainty, is hopeless unless he or she is artificially supported through the use of life-sustaining procedures.

V. OTHER PROVISIONS

(A) In the absence of my ability to give directions regarding the use of life-sustaining treatment, it is my intention that this advance directive for health care shall be honored by my family, my physician(s), and health care provider(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

(B) I understand the full import of this declaration and I am emotionally and mentally competent to make this advance directive for health care.

(C) Nothing herein shall be construed as a directive to exclude from consultation or notification any relative of mine about my health condition or dying. Written directives by me as to whether to notify or consult with certain family members shall be respected by health care workers, attorneys in fact, or surrogates.

(D) I understand that I may revoke this directive at any time.

NAME

Address: Florence, AL 35630

Date: _____

That declarant has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care proxy therein. I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness: _____

Witness: _____

Date:

I, **Name of proxy, address of proxy, Florence, Alabama 35630**, accept the proxy designation of the declarant and I **Name of Alternate proxy, address of alternate proxy, Florence, Alabama 35630**, accept the alternate proxy designation of the declarant.

DATE: _____

PROXY

DATE: _____

ALTERNATE PROXY