ADVANCE DIRECTIVE FOR HEALTH CARE

(Living Will and Health Care Proxy)

Complied from the Code of Alabama § 22-8A-4

I understand that this form may be used in the State of Alabama to make my wishes known about what medical treatment or other care I would or would not want if I become too sick to speak for myself. I understand that I am not required to have an advance directive, and that if I do have an advance directive, I should be sure that my doctor, family, and friends know I have one and know where it is located.

Section 1. Living Will

I,____, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

IF I BECOME TERMINALLY ILL OR INJURED:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

Life sustaining treatment -- Life sustaining treatment includes drugs,

machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your *initials* by either "yes" or "no":

I want to have life sustaining treatment if I am terminally ill or injured.

Yes _____ No _____

Artificially provided food and hydration (Food and water through a tube or an IV) -- I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your *initials* by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.

Yes _____ No _____

IF I BECOME PERMANENTLY UNCONSCIOUS:

Permanent unconsciousness is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life sustaining treatment -- Life sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your *initials* by either "yes" or "no":

I want to have life-sustaining treatment if I am permanently unconscious.

Yes _____ No _____

Artificially provided food and hydration (Food and water through a tube or an IV) -- I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your *initials* by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am permanently unconscious.

Yes _____ No _____

OTHER DIRECTIONS:

In addition to the directions I have listed on this form, I also want the following:

____

____

If you do not have other directions, place your *initials* here: _____ No, I do not have any other directions.

Section 2. If I need someone to speak for me.

I understand this form can be used in the State of Alabama to name a person I would like to make medical or other decisions for me if I become too sick to speak for myself. This person is called a health care proxy. I do not have to name a health care proxy. The directions in this form will be followed

even if I do not name a health care proxy.

Place your *initials* by only *one* answer:

_____ I do not want to name a health care proxy. (If you check this answer, go to Section 3)

______ I do want the person listed below to be my health care proxy. I have talked with this person about my wishes.

First choice for proxy: ____

Relationship to me: ____

Address: ____
____

City: ____ State: ________________________ Zip: __________________

Day-time phone number: ______________________ Night-time phone number: _____________________

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy: ____

Relationship to me: ____

Address: ____
____

City: ____ State: ________________________ Zip: __________________

Day-time phone number: ______________________ Night-time phone number: _____________________

Instructions for Proxy

Place your *initials* by either "yes" or "no":

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV.

Yes_____ No_____

Place your initials by only one of the following:

_____ I want my health care proxy to follow only the directions as listed on this form.

_____ I want my health care proxy to follow my directions as listed on this form and to make any decisions about things I have not covered in the form.

_____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

Section 3. The things listed on this form are what I want.

I understand the following:

If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.

If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.
If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

Name(s): ____
____

____
____

Section 4. My signature

My name: ____

The month, day, and year of my birth: ______________________________

My signature: ____________________________________

Date signed: ____

Section 5. Witnesses (need two witnesses to sign)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for or providing his or her medical care.

Name of first witness: ____

Signature: ____ ____

Date: ____

Name of second witness: ____

Signature: ____ ____

Date: ____

Section 6. Signature of Proxy

I, ____, am willing to serve as the health care proxy.

Signature: ____
______________________ Date: ______________

Signature of Second Choice for Proxy:

I, ____
_________, am willing to serve as the health care proxy if the first choice cannot serve.

Signature: ____
___________________________ Date: _______________