ALABAMA ADVANCE DIRECTIVE FOR HEALTH CARE

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you would or would not want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you 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 where death will result in the near future without the use of artificial life sustaining procedures.

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 medicine 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: 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:
Please list any other things that you want done or not done:
In addition to the directions I have listed on this form, I also direct the following:
____
____
____
____
____
(Attach additional sheets if necessary)

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

Section 2. HEALTH CARE PROXY
This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you 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:
____
____
____

Section 4.
ORGAN DONATION (OPTIONAL)
Under Alabama law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental education or research or for the advancement of medical or dental science or therapy; or to any specified individual for therapy or transplantation needed by him/her. The holder of a driver's license or identification card may also make a gift by authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's driver's

license or identification card. Revocation, suspension expiration, or cancellation of a driver's license or identification card upon which an anatomical gift is indicated does not invalidate the gift. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice that you do not want a gift made. An individual may refuse to make an anatomical gift by (1) a writing signed in the same manner as a document of gift, (2) a statement attached to or imprinted on a donor's motor vehicle operator's license, or (3) any other writing used to identify the individual as refusing to make an anatomical gift. During a terminal illness or injury, the refusal may be by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness.

You, or someone else authorized to do so, may amend or revoke your gift by signing a record or by a later-executed document of gift that either expressly amends or revokes the previous gift or does so by inconsistency. If the record is not signed by you, it must be witnessed by at least two adults, at least one of whom is a disinterested witness, and state that it has been signed and witnessed.

You may also revoke your gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law. **The donation elections you make below survive your death.**

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. **If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Alabama law.**

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.
_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:
Name of individual / institution: ____________________________

_____ Pursuant to Alabama law, I hereby give, effective on my death: (Select one)
_____ Any needed organ or parts.
_____ The following part or organs as listed below:

____
____

For the following purpose: (Select one)
_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Section 5. Execution

My signature

Your Name____
The Month, Day, and Year of your birth: ___________________________________
Your signature:____
Date signed:____

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 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 for ____________________________.
Signature: ____
Date:______________

Signature of second choice for proxy:
I, ____________________________________, am willing to serve as the health care proxy for ____________________________ if the first choice cannot serve.
Signature: ____
Date:______________

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.