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ADVANCE HEALTH CARE DIRECTIVE

I, _____, of _____, being of sound mind, voluntarily create this Advance Health Care Directive.

PRIOR DESIGNATIONS

I revoke any prior Advance Health Care Directive.

APPOINTMENT OF HEALTH CARE PROXY

In the event that I have been determined to be incapable of providing informed consent for medical, surgical, and diagnostic treatments, I wish to designate the following person as my health care proxy for health care decisions:

_____

_____

_____

_____

If the health care proxy I appoint is unwilling, unable, or unavailable to act as my health care proxy, I then appoint the following person as my health care proxy for health care decisions:

_____

_____

_____

_____

HEALTH CARE PROXY'S AUTHORITY

My health care proxy has the power to make any and all health care decisions for me, except to the extent that I state otherwise. My health care proxy and any alternate health care proxy shall have the authority to make all health care decisions regarding my care, treatment, or procedures to maintain, diagnose, or treat my physical or mental health or personal care.

If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time and I am no longer able to provide informed consent regarding my medical treatments or (2) if I should become permanently unconscious in a coma or vegetative state, my health care proxy and any alternate health care proxy shall also have the authority to make decisions regarding the providing, withholding, or withdrawing of life sustaining treatments as my health care proxy.

My health care proxy has full power to review and receive any information regarding my physical or mental health, including medical and hospital records, in accordance with the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d ("HIPPA") and the American Recovery and Reinvestment Act of 2009 ("ARRA").

My health care proxy does not have authority to act for me for any purpose other than my health care. All of my health care proxy's actions under this power have the same effect on my heirs, devisees, and personal representatives as if I were competent and acting for myself.

WHEN HEALTH CARE PROXY'S AUTHORITY BECOMES EFFECTIVE

The designation of my health care proxy will become effective if I am unable to make or communicate my health care decisions as determined by my attending physician and will remain in effect until either my death or until I regain competence and revoke it.

EFFECT OF COPY

A copy of this Instrument has the same effect as the original.

SEVERABILITY

If any part of any provision of this instrument is ruled invalid or unenforceable under applicable law, such part will be ineffective to the extent of such invalidity only, without in any way affecting the remaining parts of such provisions or the remaining provisions of this instrument.

SIGNATURE

This Advance Health Care Directive is made after full and careful thought while I am of sound mind. I am fully informed as to the contents of this document and understand the meaning of granting these powers to my agent. I fully understand that by signing this document, I will permit my health care proxy to make health care decisions for me when I am no longer able. I understand that this document gives my health care proxy the power to provide, withhold, or withdraw consent to health care treatments or procedures on my behalf; to apply for public benefits to cover the costs of my medical treatment; and to authorize my admission to or transfer from a health care facility. I further affirm that I am not signing this document as a condition of treatment or admission to a health care facility.

I execute this document, as a my free and voluntary act, on _____, in the City of _____, County of _____, State of Alabama.

Signature of _____

_____

STATEMENT OF WITNESSES

I am of at least 18 years old. I declare under penalty of perjury that _____ signed or requested that another person sign this document on their behalf in my presence. _____ is personally known to me or provided me with evidence sufficient to convince me of their identity, and they signed this document voluntarily and appear to be of sound mind and under no duress, fraud, or undue influence.

I further declare that I am not _____'s spouse, parent, child, sibling, or otherwise related to _____ through blood, marriage, or adoption. I declare that I am not a person appointed as _____'s health care representative, not entitled to any portion of _____'s estate to the best of my knowledge, and not financially responsible for _____'s health care costs. I am not _____'s health care provider, an operator or employee of a care facility, or an operator or employee of a nursing home.

Witness 1:

_____
(Signature)

_____
(Date)

_____
(Print Name)

_____
(Full Address)

Witness 2:

_____
(Signature)

_____
(Date)

_____
(Print Name)

_____

(Full Address)

SIGNATURE OF PROXY

I, _____, am willing to serve as the health care proxy for _____ as specified in this Advance Directive.

Health Care Proxy:

_____
(Signature)

_____
(Date)

_____
(Print Name)

_____
(Full Address)

I, _____, am willing to serve as the health care proxy for _____ as specified in this Advance Directive, if _____ cannot serve.

Alternate Health Care Proxy:

_____
(Signature)

_____
(Date)

_____
(Print Name)

_____
(Full Address)

LIVING WILL

If I, _____, become incapacitated and am no longer able to provide informed consent and make my wishes known to my health care providers, I direct that this Living Will be read as a true reflection of my health care wishes.

END OF LIFE CARE

If I have a terminal condition that a Physician certifies will reasonably result in my death within a relatively short period of time with no realistic hope of recovery, or I am in an irreversible coma or permanent vegetative state that a Physician certifies as having no realistic hope of recovery and that it is unlikely that I will regain consciousness, I specifically direct that:

1. I be removed from life support or any other artificial life-prolonging treatment, even if doing so will shorten my life.

_____(My Initials)

2. I NOT be artificially administered nutrition (food) or hydration (water) through tube or IV, even if it has the effect of shortening my life.

_____(My Initials)

3. I NOT be provided with comfort care and pain relief, including pain management medication.

_____(My Initials)

4. I direct that I NOT receive heart-lung resuscitation (CPR).

_____ (My Initials)

5. I direct that NOT I receive any surgeries, even if my doctors deem them necessary to prolong my life.

_____ (My Initials)

6. I direct that I NOT receive chemotherapy, even if my doctors deem it necessary to prolong my life.

_____ (My Initials)

7. I direct that I NOT receive radiation treatment, even if my doctors deem it necessary to prolong my life.

_____ (My Initials)

8. I direct that I NOT receive dialysis (kidney treatments), even if my doctors deem it necessary to prolong my life.

_____ (My Initials)

I have no further instructions regarding my end of life care.

_____ (My Initials)

THE THINGS LISTED IN THIS DOCUMENT ARE WHAT I WANT

I understand the following:

I understand that there are more options available to me than those listed here with respect to my future health care and I assure that the directions I have provided were given with knowledge of alternatives that I rejected.

_____ (My Initials)

If my doctor or hospital does not want to follow the directions I have detailed here, they must ensure that I am transferred to a doctor or hospital who will follow my instructions.

If the time comes for me to stop receiving life sustaining treatment or food or water through a tube or IV, I direct that my doctor talk about the good and bad points of doing this, and about my wishes, with _____, my health care proxy.

SIGNATURE

I understand the full import of this document and I am emotionally and mentally competent to make this document. I have written this document upon careful reflection and consultation with my Physician. I affirm that I am fully aware of other options available to me and any options that I rejected were omitted from the above intentionally. I declare that I am an adult in the state of Alabama.

Signature of _____

_____

WITNESS STATEMENT

I, the undersigned, declare under penalty of perjury that the person who signed above is personally known to me or proved their identity to me via convincing evidence. I declare that the person who signed above appeared to be eighteen (18) years of age or older and of sound mind to execute this health care document willingly and free from fraud or duress. He or she signed this document in my presence. I declare that I am not a person appointed as _____'s health care proxy, I am at least 18 years old, am not entitled to any portion of _____'s estate to the best of my knowledge, am not named as _____'s health care proxy, am not related by blood or adoption, and am not financially responsible for _____'s health care costs. I am not _____'s health care provider, an operator or employee of a care facility, or an operator or employee of a nursing home.

Witness 1:

_____
(Signature)

_____
(Date)

_____
(Print Name)

_____
(Full Address)

Witness 2:

_____
(Signature)

_____
(Date)

_____
(Print Name)

_____

(Full Address)