ALABAMA
Advance Directive
Durable Power of Attorney for Health Care and Living Will

This advance directive form is an official document where you can write down your wishes for your healthcare. If you can't make health care decisions for yourself, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, long-term care, or other types of healthcare

If you do not choose a healthcare decision maker and are too sick to make your own decisions, your care team will turn to your family to make decisions for you according to Alabama law in the following order: (1) spouse; (2) adult children; (3) parents; (4) adult brothers and sisters; (5) any next closest relative; (6) facility ethics committee. A conservator or guardian by court order overrides any of the above.

PART 1: YOUR PERSONAL INFORMATION

YOUR NAME *(Last, First, Middle)*:		
YOUR STREET ADDRESS, CITY, STATE, ZIP:		
HOME PHONE:	WORK PHONE:	CELL PHONE:

Primary Care Providers

NAME	CLINIC	OFFICE PHONE NUMBER
STREET ADDRESS, CITY, STATE, ZIP		

If the person named above can't or doesn't want to make decisions for me, or is not reasonably available, I appoint the person named below as my primary care provider:

NAME	CLINIC	OFFICE PHONE NUMBER
STREET ADDRESS, CITY, STATE, ZIP		

PART 2: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. It lets you appoint a specific person who is at least 19 years of age to make health care decisions for you if you are too sick to make decisions for yourself. This person will be called your Health Care Proxy.

Your Health Care Proxy

- Should be someone who is at least 19 years old that you trust, who knows you well, and is familiar with your values and beliefs.
- **CANNOT** be someone who works at a hospital, nursing home or similar facility where you are being treated unless you are related.

HEALTH CARE PROXY			
Place your initials in the box next to your choice.			
Initials	I designate the following individual as my proxy to make healthcare decisions for me if I am unable to decide for myself.		
NAME *(Last, First, Middle)*:			Relationship to me:
STREET ADDRESS:		CITY, STATE, ZIP:	
HOME PHONE:	WORK PHONE:		CELL PHONE:

ALTERNATE HEALTH CARE PROXY			
Fill out this section if you want to appoint a second person to make health care decisions for you, in case the first person isn't willing or able to speak for you when the time comes.			
Initials	If I revoke my proxy's authority, or if the person named above can't or doesn't want to make decisions for me, or is not reasonably available, I appoint the person named below as my Health Care Proxy.		
NAME *(Last, First, Middle)*:			Relationship to me:
STREET ADDRESS:		CITY, STATE, ZIP:	
HOME PHONE:	WORK PHONE:		CELL PHONE:

My Healthcare Decision Maker's Authority: My healthcare decision maker can make any healthcare decisions for me, but **must** follow my wishes as expressed in Part 3, even if he/she disagrees or thinks this isn't in my best interest. My healthcare decision maker can access my personal health information and medical records, and talk with my care providers about my health. If my medical choices are not clear, he or she must make those decisions in my best interest and based on what is known of my wishes. I can revoke or limit my Agent's authority at any time.

Effective Date: when my treating physician determines I cannot make my own decisions **and** when my doctor and another doctor decide I either have a terminal illness or injury or that I am permanently unconscious.

PART 3: LIVING WILL

This section of the advance directive form is called a Living Will. This section lets you write down how you want to be treated, in case you aren't able to decide for yourself anymore and helps others choose the care you would want.

LIFE SUPPORT MEASURES

If I am so sick that I might die soon:

☐ ***I do not want to receive life support treatments***. I want to focus on being comfortable.

☐ ***Try all life support treatments that my doctors think might help***.

If the treatments do not work and there is little hope of getting better (CHOOSE ONE):

☐ I want to stop life support treatments if they are not working.
☐ I want to stay on life support treatments *unless* it looks like I am suffering.
☐ I want to stay on life support treatments *even* if I look like I am suffering.

☐ Other (use additional sheets if needed):

_____

_____

_____

** **I understand that if I am pregnant, the choices I have made on this form may not be followed until after the birth of the baby.** If at any point it is determined that the baby could not possibly develop to the point of live birth with continued life-support efforts, I request that my wishes for comfort be given consideration.

COMFORT AND PAIN RELIEF

In this section, you can indicate your preferences for comfort and pain relief. Place your initials in the box next to the statements that reflect your wishes for comfort and pain relief. **Initial all that apply.**

Initials	I want to receive maximum pain relief even if it may unintentionally cause me to die sooner.
Initials	I want to receive maximum pain relief medication even if it may result in temporary dependence if I survive, recover or rebound from my current conditions and/or hospital stay.
Initials	I want a voluntary non-opioid directive. I am refusing, at my own insistence, the offer or administration of any opioid medications including in an emergency situation where I am unable to speak for myself.

CONSENT TO DONATE

☐ I want to give away as many of my organs, eyes, and tissues as possible for the purpose of donation.

☐ I only want to give away the following organs, eyes, and/or tissues for the purpose of donation:

_____

☐ I do not want to give away my organs, eyes, or tissues.

Complete this sentence if it is true. *I am already a body donor and have filled out the required consent forms with the following facility*: _____

SPECIFIC PREFERENCES ABOUT END-OF-LIFE TREATMENTS (OPTIONAL)

CPR (Cardiopulmonary Resuscitation)	
CPR is a group of procedures used when the heart stops or breathing stops as a result of a serious illness or injury.	☐ **Yes.** I would want CPR attempted, even if the burden may outweigh the benefits. ☐ **No.** I do not want CPR attempted

Kidney Dialysis	
Kidney dialysis uses machines to remove waste products and excess fluid from the body when the kidneys are not working well enough for a person to survive.	☐ **Yes.** I would want kidney dialysis, even if the burden may outweigh the benefits. ☐ **No.** I do not want my life prolonged with dialysis machines.

SPECIFIC PREFERENCES ABOUT LIFE-SUPPORT TREATMENTS (OPTIONAL)

In this section, you can indicate your preferences for life support treatments in certain situations. Think about each situation described on the left and ask yourself, "In that situation, would I want to have life-support treatments?" Place your initials in the box that best describes your treatment preference. **You may complete some, all, or none of this section. Choose only one box for each statement.**

	Yes. I would want life-support treatments	**No.** I would not want life-support treatments.
If I need to use a breathing machine to survive for the rest of my life.	Initials	Initials
If I cannot eat by mouth and depend on artificial feeding or tube feeding to get nutrition and hydration.	Initials	Initials
If I am unconscious, in a coma, or in a vegetative state, and there is little or no chance of recovery.	Initials	Initials
If I have permanent, severe, brain damage that makes me unable to recognize my family or friends (for example, severe dementia).	Initials	Initials
If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting).	Initials	Initials
If I have pain or other severe symptoms that cause suffering and cannot be relieved.	Initials	Initials
OTHER:	Initials	Initials

ADDITIONAL PREFERENCES

This section is optional. In this space you can write other important preferences for your health care that aren't described somewhere else in this document. If you need more space, you may attach extra pages and use this space to refer to the attached pages. **Be sure to initial and date every page you attach.**

_____

_____

_____

_____

_____

PART 4: SIGNATURES

YOUR SIGNATURE

By my signature below, I certify that this form accurately describes my preferences.	
SIGNATURE:	DATE:
NAME *(Printed or Typed)*:	MONTH, DAY, AND YEAR OF YOUR BIRTH:

WITNESSES SIGNATURES

WITNESS #1

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.	
SIGNATURE:	DATE:
NAME *(Printed or Typed)*:	
STREET ADDRESS:	CITY, STATE, ZIP:

WITNESS #2

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.	
SIGNATURE:	DATE:
NAME *(Printed or Typed)*:	
STREET ADDRESS:	CITY, STATE, ZIP:

PART 5: SIGNATURE AND SEAL OF NOTARY PUBLIC *(OPTIONAL)*

This Advance Directive form is valid in NMHS facilities without being notarized. However, you may need to have it notarized to be legally binding outside the NMHS health care setting. Space for a Notary's signature and seal is included below.

STATE OF _____

COUNTY OF _____

On this date, _____, the Declarant, _____, personally appeared before me and having provided verifiable identification to be the Declarant whose name is subscribed to this instrument and acknowledged to me that s/he executed the same in his/her capacity, and that by his/her signature on the instrument, executed the instrument.

I declare that s/he appears to be of sound mind and not under or subject to duress, fraud or undue influence, that s/he acknowledges the execution the same to be his/her voluntary act and deed, and that I am not the advocate, attorney-in-fact, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by any other means or process of law.

WITNESS my hand and seal.

_____
(Notary Signature)

My Commission Expires: _____
(Date)