DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For Alabama Residents

Standard State Statutory
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For Alabama Residents

Standard State Statutory Advance Directive for Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Alabama Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Alabama legislature has designed a combined Living Will and Health Care Proxy, known as an "Advance Directive for Health Care," for use by the public. There is an introduction that summarizes the scope and purpose of the documents, as well as providing directions for completion. Read it carefully to ensure that your advance directive is fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid.

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside each of the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

ADVANCE DIRECTIVE FOR HEALTH CARE

Introduction: *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 I:

LIVING WILL DECLARATION

And Personal Instructions

(Pursuant to Code of Alabama Title 22: Ch.8A 22-8A-4(h))

I (*insert name*), _____,
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:

Definition: "*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:

Definition: 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; or, _____ 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; or, _____ No

IF I BECOME PERMANENTLY UNCONSCIOUS:

Definition: 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:

Definition: 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; or, _____ 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; or, _____ No

OTHER DIRECTIONS:

(*please list any other things you want done, or not done*)

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

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If you do not have other directions, place your initials here:

_____ No, I do <u>not</u> have any other directions noted above.

SECTION II:
HEALTH CARE PROXY APPOINTMENT
If I Need Someone to Speak For Me

(Pursuant to Code of Alabama Title 22: Ch.8A 22-8A-4(h))

Introduction: *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.*

Intent to Complete: *Place your initials by only one answer*:

_____ I do not want to name a health care proxy.
(*If you initial this answer, skip 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.

APPOINTMENT OF PROXY

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

_____ Yes; or, _____ 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 III:
ADHERENCE TO MY WISHES

The things listed on this form are what I want

(Pursuant to Code of Alabama Title 22: Ch.8A 22-8A-4(h))

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 IV:
VALIDATION AND SIGNATURE

The things listed on this form are what I want

(Pursuant to Code of Alabama Title 22: Ch.8A 22-8A-4(h))

Personal Identification:

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

Your signature:

Signed:_____ Date: _____

SECTION V:
WITNESSING AND CERTIFICATION
(need two witnesses to sign)

(Pursuant to Code of Alabama Title 22: Ch.8A 22-8A-4(h))

Statement of Witnesses

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 1st witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

Name of 2nd witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

SECTION VI:
ACCEPTANCE OF APPOINTMENT
Signature of Proxy

(Pursuant to Code of Alabama Title 22: Ch.8A 22-8A-4(h))

Signature of First Choice for Proxy:

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

Signed:_____ Date: _____

Signature of Second Choice for Proxy:

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

Signed:_____ Date: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC *(notarization is **not** required. However, Lifecare staff recommend both witnessing and notarization in the event your witnesses ever become unavailable in the future*):

State of ALABAMA.

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (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 other operation of law.

WITNESS my hand and official seal:

_____ **Notary Seal:**

Signature of Notary Public

_____

Date Commission Expires