Advance Health-Care Directive

(Delaware Code Annotated title 16, §§ 2501 to 2518)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care agent in case of my incapacity.

2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.

3. **Regarding end-of-life matters:** [initial one of the two choices]

   (a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.

   (b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.

4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:

   _____

   _____

   _____

   _____

   _____

5. I give no one (including my agent) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.

6. Apart from the matters covered above, I appoint the person named herein as my agent to make health-care decisions for me. I give my agent full power and authority to consent to or to refuse treatment (including artificial nutrition and hydration) on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed agent is unavailable, unable, or unwilling to serve, I appoint an alternate agent herein to serve with the same power and authority.

7. **Regarding health-care decisions during pregnancy [if applicable]:** I direct that my health-care provider and my health-care agent fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my health-care agent has the authority to make health-care decisions for me even while I am pregnant.

8. I understand the purpose and effect of this document.

_____ _____

(Signature*) (Date)

_____

(Address)

STATEMENT OF WITNESSES: [Note: If the declarant (the person who signed on page 1) is a patient in a nursing facility at the time this document is signed, one of the witnesses must be a patient advocate or ombudsman.]

SIGNED AND DECLARED by the above-named declarant as and for the declarant's written declaration under §§ 2502 and 2503 of Title 16 of the Delaware Code, in our presence, who in the declarant's presence, at the declarant's request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

A. That the declarant is mentally competent.

B. That neither of us is prohibited by § 2503 of Title 16 of the Delaware Code from being a witness. Neither of us (1) Is related to the declarant by blood, marriage, or adoption; (2) Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of executing of this document, is so entitled by operation of law then existing; (3) Has, at the time of the execution of this document, a present or inchoate claim against any portion of the estate of the declarant; (4) Has a direct financial responsibility for the declarant's medical care; (5) Has a controlling interest in or is an operator or an employee of a residential long-term health-care institution in which the declarant is a resident; or (6) Is under 18 years of age. **Also, neither of us is the health-care agent or alternate health-care agent appointed in this document.**

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home, or related institution, one of the witnesses is, at the time of the execution of this document, a patient advocate or ombudsman designated by the Department of Health and Social Services.

_____	_____
(Signature of witness)	(Signature of witness)
_____	_____
(Address)	(Address)

HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

ALTERNATE HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

*** Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your health-care agents). You should sign this document in the presence of two witnesses. You may appoint any adult to be your agent except for a nonrelative operator, employee, or individual with a controlling interest in a residential long-term health-care institution at which you are receiving care. A "nonrelative" is a person who is not related to you by blood, marriage, or adoption.

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(signed document inside)

NO BLOOD