Durable Health Care Power of Attorney

(Montana Code Annotated §§ 72-5-501 to 72-5-502 and § 50-9-103(4))

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 <u>one</u> 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 the providing, withholding, or withdrawing of life-sustaining treatment and 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. This Durable Health Care Power of Attorney becomes effective upon my disability or incapacity.

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 sign this document on the date indicated below.

_____ _____
(Signature*) (Date)

_____
(Address)

STATEMENT OF WITNESSES: I declare that the person who signed this document above is personally known to me and that he or she signed this Durable Health Care Power of Attorney in my presence. He or she appears to be of sound mind and free from duress, fraud, or undue influence. I am 18 years of age or older. **I am not the health-care agent or alternate agent appointed in this document.**

_____ _____
(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. However, it is recommended that you not appoint your physician, any of your physician's employees, or any employee of a hospital or nursing home where you might be a patient unless the person you appoint is related to you by blood, marriage, or adoption.

Durable Health Care Power of Attorney
(signed document inside)

NO BLOOD