Advance Health Care Directive

(Utah Code Annotated §§ 75-2a-101 to 75-2a-125)

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 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. **Regarding admission to licensed health-care facilities:** I authorize my health-care agent to admit me, if necessary, to a licensed health-care facility, such as a hospital, nursing home, assisted living, or other facility, for convalescent, recuperative, or other long-term placement care.

   [initial here, if you agree] ____________

9. I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form, naming a health-care agent, that I have completed in the past.

______________________________ (Signature*) ______________ (Date)

______________________________ (Address)

STATEMENT OF WITNESSES: I have witnessed the signing of this directive, I am 18 years of age or older, and **I am not (1) the health-care agent or alternate agent appointed in this directive,** (2) related to the declarant (the person who signed above) by blood or marriage, (3) entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant, (4) a beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer on death deed that is held, owned, made, or established by, or on behalf of, the declarant, (5) entitled to benefit financially upon the death of the declarant, (6) entitled to a right to, or interest in, real or personal property upon the death of the declarant, (7) directly financially responsible for the declarant's medical care, (8) a health-care provider who is providing care to the declarant or an administrator at a health-care facility in which the declarant is receiving care, or (9) the person who signed this directive on behalf of the declarant.

______________________________ (Signature of witness) ______________________________ (Signature of witness)

______________________________ (Address) ______________________________ (Address)

HEALTH-CARE AGENT*

Name: ______________________________

Address: ______________________________

____

Telephone(s): ______________________________

____

ALTERNATE HEALTH-CARE AGENT*

Name: ______________________________

Address: ______________________________

____

Telephone(s): ______________________________

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*** Note:** Before signing this document, fill out this 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 (1) your nonrelative health-care provider, or (2) a nonrelative owner, operator, or employee of the health-care facility at which you are receiving care. A "nonrelative" is a person not related to you by blood, marriage, or adoption.

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(signed document inside)

NO BLOOD