Advance Directive

(Maryland Code Annotated, Health General §§ 5-601 to 5-618)

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. I refuse to predonate and store my blood for later infusion.

3. **Regarding minor fractions of blood:** [initial those that apply]

   (a) _____ I REFUSE ALL (b) _____ I REFUSE ALL EXCEPT: _____

   _____

   (c) _____ I may be willing to accept some minor blood fractions, but the details will have to be discussed with me if I am conscious or with my health-care agent in case of my incapacity.

4. **Regarding medical procedures involving the use of my own blood,** except diagnostic procedures, such as blood samples for testing: [initial those that apply]

   (a) _____ I REFUSE ALL (b) _____ I REFUSE ALL EXCEPT: _____

   _____

   (c) _____ I may be willing to accept certain medical procedures involving my blood, but the details will have to be discussed with me if I am conscious or with my health-care agent in case of my incapacity.

5. **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.

6. **Regarding other health-care instructions** (such as current medications, allergies, and medical problems):

   _____

   _____

   _____

   _____

   _____

7. 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.

8. Apart from the matters covered above, I appoint the person named below 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 below to serve with the same power and authority.

9. _____ _____
Signature Date

_____
Address

10. STATEMENT OF WITNESSES: I am at least 18 years of age and **I am not appointed as agent or alternate agent by this document.** I declare that the declarant (the person who signed this document above) is personally known to me and appears to be of sound mind and acting of his or her own free will. The declarant signed (or asked another to sign) this document in my presence. Also, at least one witness below is a person who is not knowingly entitled to any portion of the declarant's estate or to any financial benefit in the event of the declarant's death.

_____ _____
Signature of witness Signature of witness

_____ _____
Address Address

HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

ALTERNATE HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

* Note: You may appoint any adult to be your agent. However, the following persons may not serve as your agent unless they are related to you by blood, marriage, or adoption, or they are a close friend of yours: an owner, operator, or employee of a health-care facility from which you are receiving health care, or a spouse, parent, child, or sibling of such an owner, operator, or employee.

Advance Directive
(signed document inside)

NO BLOOD