Section 22-8A-4

Advance Directive for Health Care; living will and health care proxy.

(a) Any competent adult may execute a living will directing the providing, withholding, or withdrawal of life-sustaining treatment and artificially provided nutrition and hydration. Artificially provided nutrition and hydration shall not be withdrawn or withheld pursuant to the living will unless specifically authorized therein.

(b) A competent adult may execute at any time a living will that includes a written health care proxy designation appointing another competent adult to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment and artificially provided nutrition and hydration. Artificially provided nutrition and hydration shall not be withdrawn or withheld pursuant to the proxy designation unless specifically authorized therein. A proxy designation made pursuant to this section shall be accepted in writing by the individual being appointed. The acceptance shall be evidenced in writing and attached to the proxy designation. The proxy designation may be a separate document or part of a living will.

(1) The designation of an attorney-in-fact, made pursuant to Section 26-1-2, as amended from time to time, who is specifically authorized to make decisions regarding the providing, withholding, or withdrawing of life-sustaining treatment or artificially provided nutrition and hydration in instances involving terminal illness or injury and permanent unconsciousness, constitutes for purposes of this chapter a proxy designating another individual to act for the declarant pursuant to this subsection, provided, however, that the authority granted to an attorney-in-fact to make such decisions shall be the same as the authority granted in this chapter to a health care proxy. The appointment shall be limited to the specific directions enumerated in the appointment.

(2) Any powers granted to a health care proxy in an advance directive for health care executed pursuant to this subsection that permit a health care proxy to make general health care decisions not related to the provision, withdrawal, or withholding of life-sustaining treatment or artificially provided nutrition and hydration shall be limited to those powers permitted under the Alabama Durable Power of Attorney Act, Section 26-1-2, as the same shall be amended from time to time.

(3) Unless otherwise provided in the proxy designation or in an order of divorce, dissolution, or annulment of marriage or legal separation, the divorce, dissolution, or annulment of marriage of the declarant revokes the designation of the declarant's former spouse as health care proxy.

(4) Under no circumstances shall the patient's health care provider or a nonrelative employee of the patient's health care provider make decisions in the capacity of a health care proxy.

(c) Any advance directive for health care made pursuant to this chapter shall be:

(1) In writing;

(2) Signed by the person making the advance directive for health care, or by another person in the declarant's presence and by the declarant's expressed direction;

(3) Dated; and

(4) Signed in the presence of two or more witnesses at least 19 years of age, neither of whom shall be the person who signed the advance directive for health care on behalf of and at the direction of the person making the advance directive for health care, appointed as the health care proxy therein, related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of this state or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care.

(d) An advance directive for health care shall become effective when: (1) The attending physician determines that the declarant is no longer able to understand, appreciate, and direct his or her medical treatment; and (2) two physicians,

one of whom shall be the attending physician, and one of whom shall be qualified and experienced in making such diagnosis, have personally examined the declarant and have diagnosed and documented in the medical record that the declarant has either a terminal illness or injury or is in a state of permanent unconsciousness.

(e) The advance directive for health care of a declarant who is known by the attending physician to be pregnant shall have no effect during the course of the declarant's pregnancy.

(f) It shall be the responsibility of the declarant to provide a copy of the advance directive for health care to his or her attending physician and other health care providers rendering treatment to the declarant. The health care provider shall make the advance directive for health care, or a copy of the advance directive for health care, a part of the declarant's medical records.

(g) In the event a declarant has executed both a living will and a proxy designation, the decisions by the health care proxy duly designated under this chapter regarding the providing, withholding, or withdrawal of life-sustaining treatment or artificially provided nutrition or hydration, shall take precedence over a living will of a declarant, unless the declarant's living will or proxy designation indicates otherwise.

(h) The advance directive for health care shall be substantially in the following form, but in addition may include other specific directions. Should any specific directions be held to be invalid, the invalidity shall not affect other directions of the advance directive for health care which can be given effect without the invalid direction, and to this end the directions in the advance directive for health care are severable.

ADVANCE DIRECTIVE FOR HEALTH CARE

(Living Will and Health Care Proxy)

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 1. Living Will

I, _____, 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:

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 - 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 ____ 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 ____ No

IF I BECOME PERMANENTLY UNCONSCIOUS:

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 - 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 ____ 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 ____ 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: _____

If you do not have other directions, place your initials here: ____ No, I do not have any other directions.

Section 2. If I need someone to speak for me.

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.

Place your initials by only one answer:

_____ I do not want to name a health care proxy. (If you check this answer, go 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.

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 want my health care proxy to make decisions about whether to give me food and water through a tube or an IV. ____ Yes ____ 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 3. The things listed on this form are what I want.

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 4. My signature

Your name: _____

The month, day, and year of your birth: _____

Your signature: _____

Date signed: _____

Section 5. Witnesses (need two witnesses to sign)

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 first witness: _____

Signature: _____

Date: _____

Name of second witness: _____

Signature: _____

Date: _____

Section 6. Signature of Proxy

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

Signature: _____ Date: _____

Signature of Second Choice for Proxy:

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

Signature: _____ Date: _____

(Acts 1981, No. 81-772, p. 1329, §4; Acts 1997, No. 97-187, p. 281, §1; Act 2001-658, p. 1352, §1.)