Durable Power of Attorney for Health Care

(Rhode Island General Laws §§ 23-4.10-1 to 23-4.10-12)

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age and a resident of the state of Rhode Island for this document to be legally valid and binding.

This document gives the person you appoint as your agent (the attorney in fact) the power to make health-care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health-care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health-care decisions for you if your agent: (1) Authorizes anything that is illegal, (2) Acts contrary to your known desires, or (3) Where your desires are not known, does anything that is clearly contrary to your best interests.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death except to inform your family or next of kin of your desire, if any, to be an organ and tissue donor.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health-care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

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 sign my name to this Durable Power of Attorney for Health Care on the date indicated below.

_____ _____
(Signature*) (Date)

_____
(Address)

STATEMENT OF WITNESSES: I declare under penalty of perjury that the person who signed or acknowledged this document above is personally known to me to be the principal, that the principal signed or acknowledged this document in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that **I am <u>not</u> the person appointed as health-care agent or alternate agent by this document,** and that I am not a health-care provider, an employee of a health-care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

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

_____ _____
(Address) (Address)

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION: I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon his or her death under a will now existing or by operation of law.

_____ _____
(Signature) (Signature)

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 <u>except</u> (1) your treating health-care provider, (2) a nonrelative employee of your treating health-care provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility. A "nonrelative" is a person not related to you by blood, marriage, or adoption.

Durable Power of Attorney for Health Care
(signed document inside)

NO BLOOD