Durable Power of Attorney for Health Care

(Missouri Revised Statutes §§ 404.800 to 404.872)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint an attorney in fact 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 attorney in fact) 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 attorney in fact to make health-care decisions for me. I give my attorney in fact full power and authority to consent to or to refuse treatment (including the authority to direct a health-care provider to provide, withhold, or withdraw artificially supplied 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 attorney in fact is unavailable, unable, or unwilling to serve, I appoint an alternate attorney in fact herein to serve with the same power and authority.
7. This is a Durable Power of Attorney for Health Care and the authority of my attorney in fact, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.
8. **Regarding health-care decisions during pregnancy [if applicable]:** I direct that my health-care provider and my attorney in fact fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my attorney in fact has the authority to make health-care decisions for me even while I am pregnant.
9. THIS DOCUMENT MUST BE WITNESSED BY TWO PERSONS AND NOTARIZED.

   In witness whereof, I sign my name to this document on the date indicated below.

_____ _____

(Signature*) (Date)

_____

(Address)

STATEMENT OF WITNESSES: The principal (the person who signed on page 1) voluntarily signed this document 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 person who signed this document on behalf of and at the direction of the principal. **I am not the attorney in fact or alternate attorney in fact appointed in this document.**

_____ _____

(Signature of witness) (Signature of witness)

_____ _____

(Address) (Address)

AND

STATE OF MISSOURI)
) ss.
COUNTY OF _____)

On this ____ day of _____, 20 ___ before me personally appeared _____ (name of principal), to me known to be the person described in and who executed the foregoing Durable Power of Attorney for Health Care, and acknowledged to me that he/she executed the same as his/her free act and deed. In witness whereof, I hereunto set my hand and official seal.

My Commission expires: _____

_____

(Notary Public)

ATTORNEY IN FACT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

ALTERNATE ATTORNEY IN FACT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

*** Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your attorneys in fact). This document must be signed in the presence of two witnesses and acknowledged before a notary public. You may appoint any adult to be your attorney in fact except (1) your nonrelative attending physician, (2) a nonrelative employee of your attending physician, or (3) a nonrelative owner, operator, or employee of a health-care facility in which you are a patient or resident. A "nonrelative" is a person not related to you by marriage or blood within the second degree of affinity or consanguinity.

Durable Power of Attorney for Health Care

(signed document inside)

NO BLOOD