

# Health Care Proxy

(Massachusetts General Laws chapter 201D)

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.

\_\_\_\_\_  
(Signature\*)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Address)

**STATEMENT OF WITNESSES:** We affirm that the person who signed this document above did so in our presence and appeared to be at least 18 years of age, of sound mind, and under no constraint or undue influence. **Neither of us is named as the health-care agent or alternate agent in this document.**

\_\_\_\_\_  
(Signature of witness)

\_\_\_\_\_  
(Signature of witness)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Address)

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**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 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 except for a nonrelative administrator, operator, or employee of a health-care facility where you are a patient or resident or have applied for admission at the time you sign this document. A “nonrelative” is a person not related to you by blood, marriage, or adoption.  
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**Health Care Proxy**  
(signed document inside)

**NO BLOOD**

