Designation of Patient Advocate

(Michigan Compiled Laws §§ 700.5501 to 700.5520)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a patient advocate 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 patient advocate) 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 patient advocate to make health-care decisions for me when I am unable to participate in medical or mental health treatment decisions. I give my patient advocate full power and authority to consent to or to refuse treatment 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. I expressly authorize my patient advocate to make decisions on my behalf about the providing, withholding, or withdrawing of life-sustaining treatment that I acknowledge could or would allow my death. If my first appointed patient advocate is unavailable, unable, or unwilling to serve, I appoint a successor patient advocate 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 patient advocate fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my patient advocate has the authority to make health-care decisions for me even while I am pregnant.
8. I sign this document voluntarily, and I understand its purpose.

_____ _____

(Signature of patient*) (Date)

_____

(Address)

STATEMENT OF WITNESSES: I declare that the patient signed this document in my presence and appears to be of sound mind and under no duress, fraud, or undue influence. **I am not (1) the patient advocate or successor patient advocate appointed in this document,** (2) the patient's spouse, parent, child, grandchild, brother or sister, (3) the patient's presumptive heir, (4) a known beneficiary of the patient's will at the time of witnessing, (5) the patient's physician, (6) an employee of a life or health insurance provider for the patient, (7) an employee of a health facility that is treating the patient, (8) an employee of a home for the aged where the patient resides or, (9) an employee of a community mental health services program or hospital that is providing mental health services to the patient.

_____ _____

(Signature of witness) (Signature of witness)

_____ _____

(Address) (Address)

ACCEPTANCE BY PATIENT ADVOCATE AND SUCCESSOR PATIENT ADVOCATE:

(1) This patient advocate designation is not effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in section 5506, the authority remains exercisable after the patient's death.

(2) A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.

(3) This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(4) A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(5) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(6) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

(7) A patient may revoke his or her patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

(8) A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

(9) A patient advocate may revoke his or her acceptance of the patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

(10) A patient admitted to a health facility or agency has the rights enumerated in section 20201 of the public health code, 1978 PA 368, MCL 333.20201.

I understand the above conditions and I accept the appointment as patient advocate or successor patient advocate for

_____ (print patient's full name).

_____ _____

(Signature of patient advocate / Date) (Signature of successor patient advocate / Date)

_____ _____

(Address) (Address)

PATIENT ADVOCATE*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

SUCCESSOR PATIENT ADVOCATE*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

*** Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your patient advocates). You should sign this document in the presence of two witnesses and have your patient advocates sign the above acceptance statement. You may appoint any adult to be your patient advocate. However, it is recommended that you not appoint your physician, any of your physician's employees, or any employee of a hospital or nursing home where you might be a patient unless the person you appoint is related to you by blood, marriage, or adoption.

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(signed document inside)

NO BLOOD