ALABAMA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
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CARINGINFO

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all of the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. Alabama does not maintain an Advance Directive Registry, but you may file your advance directive with the office of the probate judge in the county in which you reside. Although no one is required to search for your advance directive, filing your advance directive may help your health care provider and loved ones be able to find a copy of your directive in the event you are unable to provide one.

6. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Alabama Advance Directive for Health Care

This packet contains an Alabama Advance Directive for Health Care which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself. This document is in substantially the same form as set forth in the Alabama Natural Death Act.

Section 1 of this document is your state's Living Will. It lets you discuss your wishes about medical care in the event that you are permanently unconscious or develop a terminal condition and can no longer make your own medical decisions.

Section 2 of this document permits the appointment of a Health Care Proxy. This section lets you name someone to make decisions about your medical care, including decisions about life-sustaining treatment, if you can no longer speak for yourself.

Section 3 explains some of the limitations of this document and allows you to list the people you want your doctor to talk to if the time comes for you to stop receiving life-sustaining treatment.

Section 4 of this document is an optional organ donation form that will allow you to make or refuse to make a donation of your organs and tissues.

Section 5 is for your signature. Your advance directive must be signed in the presence of two witnesses.

Section 6 is a proxy signature form. Alabama law requires that your proxy accept his or her role in writing. If your proxy is unavailable to sign this document immediately, a copy of the entire form should be mailed to the proxy, who should then return a signed copy of the proxy signature page.

Your Alabama advance directive for health care goes into effect when your doctor determines that you are no longer able to understand, appreciate and direct your medical treatment, and your doctor and one other doctor experienced in making the diagnosis determine that you are permanently unconscious or terminally ill and document such diagnosis in your medical record.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney.

Note: This document will be legally binding only if the person completing the document is a competent adult, 19 years of age or older.

Instructions for Completing Your Alabama Advance Directive for Health Care

How do I make my Alabama Advance Directive for Health Care legal?

The law requires that you sign your document, or direct another to sign it, in the presence of two witnesses, who must be at least 19 years of age.

Your witnesses **cannot** be:

- your appointed health care proxy,
- related to you by blood, adoption or marriage,
- entitled to any portion of your estate upon your death, either through your will or under the laws of interstate succession,
- directly financially responsible for your medical care, or
- the person who signed your document on your behalf.

These witnesses must also sign the document to show that they personally know you, believe you to be of sound mind, and that they do not fall into any of the categories of people who cannot be witnesses.

Note: You do not need to notarize your Alabama Advance Directive.

Can I add personal instructions to my Living Will?

One of the strongest reasons for naming a proxy is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your proxy carry out your wishes, but be careful that you do not unintentionally restrict your proxy's power to act in your best interest. In any event, be sure to talk with your proxy about your future medical care and describe what you consider to be an acceptable "quality of life."

Whom should I appoint as my proxy?

Your proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second person as your alternate proxy. The alternate will step in if the first person you name as a proxy is unable, unwilling, or unavailable to act for you.

Instructions for Completing Your Alabama Advance Directive for Health Care (continued)

What if I change my mind?

You may revoke your Advance Directive for Health Care at any time by:

- obliterating, burning, tearing or otherwise destroying or defacing the document,
- executing, or directing another person to execute, a signed and dated written revocation (formal statement that you have changed your mind), or
- orally expressing your intent to revoke the Advance Directive for Health Care in the presence of a witness, 19 years of age or older, who must sign and date a written confirmation that you made an oral revocation. An oral revocation becomes effective once the signed and dated confirmation is given to your doctor or health care provider, who will then make it a part of your medical record.

What other important facts should I know?

The directions of a pregnant patient's Alabama Advance Directive for Health Care authorizing the providing, withdrawal or withholding of life-sustaining treatments and artificially provided nutrition and hydration will not be honored due to restrictions in the state law.

Your proxy, if you appoint one, does not have authority to authorize psychosurgery, sterilization, or abortion—unless it is necessary to save your life—or to have you involuntarily hospitalized or treated for mental illness.

INSTRUCTIONS

PRINT YOUR NAME

PLACE YOUR INITIALS BY EITHER YES OR NO

PLACE YOUR INITIALS BY EITHER YES OR NO

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 where death will result in the near future without the use of artificial life sustaining procedures.

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 medicine and treatments that ease my pain and keep me comfortable.

PLACE YOUR INITIALS BY EITHER YES OR NO

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:

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

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_____

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

OTHER DIRECTIONS:

Please list any other things that you want done or not done:

In addition to the directions I have listed on this form, I also direct the following:

IF YOU DO NOT HAVE OTHER DIRECTIONS, PLACE

YOUR INITIALS HERE

If you do not have other directions, place your initials here:

_____No, I do not have other directions.

PLACE YOUR INITIALS BY ONLY ONE ANSWER

PRINT THE NAME, RELATIONSHIP AND ADDRESS OF YOUR PROXY

PRINT THE NAME, RELATIONSHIP AND ADDRESS OF YOUR ALTERNATE PROXY

Section 2. HEALTH CARE PROXY

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.

This Section 2 creates a power of attorney that shall become effective upon the disability, incompetence, or incapacity of the principal, and is in substantially the same form as set forth in the Alabama Natural Death Act.

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:_____

INITIAL
YES OR NO

PLACE YOUR INITIALS BEFORE ONE OF THE THREE OPTIONS

LIST THE PEOPLE YOU WOULD WANT YOUR DOCTOR TO TALK WITH

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 that 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:

_____

_____

_____

ORGAN DONATION (OPTIONAL)

Section 4.

ORGAN DONATION (OPTIONAL)

In the space below you may make a gift yourself or state that you do not want to make a gift. **The donation elections you make below survive your death.**

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. **If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Alabama law.**

CHECK THE OPTION THAT REFLECTS YOUR WISHES

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:
Name of individual / institution: _____

_____Pursuant to Alabama law, I hereby give, effective on my death: (Select one)

_____ Any needed organ or parts.

_____The following part or organs listed below:

CHECK THE OPTION THAT REFLECTS YOUR WISHES. ADD PERSONAL INSTRUCTIONS, IF ANY

For the following purpose: (Select one)

_____ Any legally authorized purpose.

_____Transplant or therapeutic purposes only.

PRINT YOUR NAME, THE MONTH, DAY AND YEAR OF YOUR BIRTH

SIGN AND DATE YOUR DOCUMENT

WITNESSING PROCEDURE

WITNESSES MUST SIGN THEIR NAMES

WITNESS #1

WITNESS #2

Section 5. Execution

My signature

Your Name_____

The Month, Day, and Year of your birth: _____

Your signature:_____

Date signed:_____

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:_____

THE PROXY AND ANY ALTERNATE PROXY MUST PRINT THEIR NAMES AND SIGN AND DATE THE DOCUMENT

IF EITHER PROXY IS UNAVAILABLE TO SIGN THIS DOCUMENT IMMEDIATELY, A COPY OF THE ENTIRE FORM SHOULD BE MAILED TO THE PROXY, WHO SHOULD THEN RETURN A SIGNED COPY OF THE PROXY SIGNATURE PAGE.

Section 6. Signature of Proxy

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

proxy for _____.

Signature: _____

Date:_____

Signature of second choice for proxy:

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

proxy for _____if the first choice cannot serve.

Signature: _____

Date:_____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Alabama Advance Directive for Health Care, Now What?

1. Your Alabama Advance Directive for Health Care is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Alabama law requires that your proxy accept his or her role in writing. If your proxy is unavailable to sign this document immediately, a copy of the entire form should be mailed to the proxy, who should then return a signed copy of the proxy signature page.

3. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

4. Be sure to talk to your agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

5. Alabama does not maintain an Advance Directive Registry, but you may file your advance directive with the office of the probate judge in the county in which you reside. Although no one is required to search for your advance directive, filing your advance directive may help your health care provider and loved ones find a copy of your directive in the event you are unable to provide one.

6. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

7. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

8. Remember, you can always revoke your Alabama document.

9. Be aware that your Alabama document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop. We suggest you speak to your physician for more information. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

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YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

OR donate online today: www.NationalHospiceFoundation.org/donate