

STATE BOARD OF HEALTH  
ADMINISTRATIVE CODE

CHAPTER 420-5-19  
ADVANCE DIRECTIVES

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**420-5-19-.01 Advance Directives.** Surrogate health care decision makers, as authorized by Act 97-187, shall complete the form attached hereto as Appendix 1 which, when properly completed and duly notarized, shall constitute the certification of the surrogate as required by the act. This form is to be used in fulfillment of the purposes of Act 97-187.

**Author:** Rick Harris

**Statutory Authority:** Act No. 97-187.

**History: New Rule:** Filed August 20, 1997; effective September 24, 1997.



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APPENDIX 1

CERTIFICATION OF HEALTH CARE DECISION SURROGATE

PATIENT'S NAME:
SURROGATE'S NAME:

I certify that:

(a) I am at least nineteen years old.

(b) The patient whose name is given above either has not, to my knowledge, made an advance directive for health care (living will or durable power of attorney), or the patient has executed an advance directive for health care, but the document fails to address his or her present circumstances.

(c) I have consulted with the physician who is now overseeing the patient's care.

(d) I am qualified to act as a surrogate health care decision maker for this patient because:

I. My relationship to the patient is the one indicated by checkmark below.

II. I have spoken to or attempted to speak to all other adults, if there are any, who fit into my category, and to all those who fit into a higher category (on the list below, a higher category is one listed before my category). Each such person that I spoke to has either agreed that I may act as surrogate, or has expressed no objection to my acting as surrogate.

III. If I have not spoken to any such person, it is because the person is in an unknown location, or because he or she is in a location so remote that he or she cannot, as a practical matter, be contacted in a timely fashion, or because he or she has been adjudged incompetent and remains incompetent today.

1. I am the judicially-appointed guardian of the patient. My guardianship appointment specifically gives me the authority to make health care decisions for the patient.

2. I am the husband or wife of the patient.

3. I am a child of the patient.

4. I am a parent of the patient.

5. I am a brother or sister of the patient.

6. I am another person related to the patient by blood. To my knowledge, the patient has no living relatives, or the patient's closer living relatives either cannot or will not serve as surrogates. I am the patient's

7. The patient has not known relatives who are able and willing to act as surrogate. I am a representative of the ethics committee at the facility where the patient is being treated or I am a representative of some other committee duly appointed to make health care decisions for this patient.

(e) I understand that under the laws of Alabama certification on this form of any information known by me to be false is a class C felony, which has a penalty of up to ten years imprisonment, and a fine of up to \$5,000.

Signature Of Surrogate

Sworn to (or affirmed) and subscribed before me this \_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public