STATE BOARD OF HEALTH
ADMINISTRATIVE CODE

APPENDIX I
CERTIFICATION OF HEALTH CARE DECISION SURROGATE

PATIENT'S NAME: _____
SURROGATE'S NAME:_____

I certify that:

(a) I am at least 19 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 and to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment or artificially provided nutrition and hydration in instances involving terminal illness or injury and permanent unconsciousness.

_____2. I am the husband or wife of the patient and am neither legally separated from the patient nor a party to a divorce proceeding with 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 other 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) Under penalty of perjury, I affirm that I am exercising my best independent judgment and agreeing to do what I believe the patient desires. 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 10 years imprisonment, and a fine of up to $5,000.

_____
Signature of Health Care Decision Surrogate

Witness to the Signature of the Health Care Decision Surrogate (need two witnesses to sign):

By signing this document, I hereby certify that I am at least 19 years of age; that I have witnessed the signature of the individual signing as the surrogate; and that I am not the patient's health care provider or a nonrelative employee of the patient's health care provider.

Name of first witness: _____

Signature: _____

Date: _____

Name of second witness: _____

Signature: _____

Date: _____

Author: Rick Harris
Statutory Authority: Act No. 97-187.
History: New Rule: Filed August 20, 1997; effective September 24, 1997. **Amended:** Filed February 21, 2018; effective April 8, 2018. **Amended:** Published August 31, 2022; effective October 15, 2022.