

**In the name of Allah, Most Beneficent, Most Merciful**

**ISLAMIC REQUIREMENT IN A LIVING WILL**

**FOR**

**WRITING YOUR OWN LIVING WILL/POWER**

**OF ATTORNEY FOR HEALTH CARE\***

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## **Dear Fellow Muslim,**

May the Peace of God, His Mercy and His Blessings be Upon You.

**You know that the Islamic Religion has its own requirement for health care, especially in the case of long and/or final illness or injury. It also has requirement for funeral and burial.**

**Fortunately the Islamic requirements are all consistent with human reason and the laws in our Fifty States.**

**The Prophet Muhammad, May Peace and Prayers be Upon Him, ordained that for illness or injury one should take medication. He said: “take medicine, surely God has not created an illness that He did not create a medicine for.” It is well known through several reports that he did not allow sufferance be inflicted on any person or on one’s own self. Suicide is obviously one of the gravest sins in our Religion.**

**Besides, according to the teaching of our religion disposition of a body can only be done through washing, wrapping in a simple cloth and burial in the ground with dignity and respect because a human body is honored dead or alive.**

**Partnership for Caring, a non-profit organization that provides support and counseling for the old has prepared forms for LIVING WILL for Health Care in case of incapacity. There is special form for each of the Fifty States in our country so that no matter where you live you can use the form of your state, sign it and keep it in a safe and known place in case it may become needed.**

**From the point of view of our Islamic Religion, these forms are a great help, but they need modifications in the options they provide so that they will express the desire of a Muslim, female or male to be treated according to her/his religion in case she/he is not able to make decision on her/his own.**

**What you need to do is two steps as follows:**

**STEP ONE:**

Download the Living Will/Power of Attorney for Health Care that is relevant to your state from the Website of Partnership For Caring: [www.partnershipforcaring.org](http://www.partnershipforcaring.org) . It has forms for all the 50 states according to their own local laws. Follow given instructions for filling the form and signing it. These forms are free for personal use so is this service of the ISLAMIC SOCIETY OF NORTH AMERICA (ISNA).

**STEP TWO:**

Make the following changes; they are required form Shari'ah (Islamic Law) point of view.

**1. Add under Limitation on the Authority of the Agent:**

My agent shall take any decision regarding my health care on the basis of the Islamic principles. According to these principles life is invaluable. These principles require the provision of health care as long as there is the slightest hope of life in the body; they also require minimization of

**pain.**

**If at any time I should have a terminal condition and permanently unconscious state and two physicians, one of them may be my attending physician and the other should be specialized in the area of my illness or injury, determine that there can be no recovery from such condition and my death is imminent and the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld and/or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain.**

**I do desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to artificially prolong the process of dying.**

**If two physicians determine that my brain died, any blood circulation or life prolonging procedures must be withdrawn unless they are needed for the implementation of Part 2 of this Advance Health Care Directive.**

**2. Add under Agent's Obligations:**

**After the word “consider”:  
the basic tenets and principles of Islam and the Islamic  
Law (Shari’ah).**

**3. Under Agent’s Post Death Authority:**

**After the word “direct”:  
Delete the phrase “the disposition of my remains”  
And put in its place: my funeral and burial**

**4. Delete part 2:**

**This is because we dealt with the Shari’ah approach to end  
of life illness, pain and life prolonging procedure in the  
first addition to limit the agent’s authority.**

**5. Renumber part 3 as Part 2**

**And change the reference to part 3 in Sections (4) and (5)  
to make it (2) instead.**

**6. Under donation of organs**

Add after a):

Except for Testicles/Ovary and Penis/Vagina,

**7. Renumber Part 4 as Part 3.**

**8. Renumber Sections of new Part 2 and new Part 3.**

**FINALLY,**

**IF** you have a question . . . and you look for a free help, for personal use only, please visit [www.isna.net](http://www.isna.net) or [www.kahf.net](http://www.kahf.net) or Ask the Scholar at [www.islamonline.net](http://www.islamonline.net)

**ATTACHED** is a revised “Power of Attorney for Health Care” in the State of California, given as an example. Certainly before printing it you have to delete the irrelevant words in the highlighted.

# CALIFORNIA

## ADVANCE HEALTH CARE DIRECTIVE

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### **Explanation**

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or an employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a co-worker. Your supervising health care provider can never act as your agent.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (b) Select or discharge health care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedures and programs of medication; and
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation;
- (e) Make anatomical gifts, authorize an autopsy, and direct the disposition of your remains.

Part 2 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility. You have the right to revoke this advance health care directive or replace this form at any time.



# PART 1

## POWER OF ATTORNEY FOR HEALTH CARE

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(1) **DESIGNATION OF AGENT:** I designate the following individual as my agent to make health care decisions for me:

-----  
(Name of individual you choose as agent)  
-----  
-----  
(address) (city) (state) (zip code)  
-----  
(home phone) (work phone)

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

-----  
(Name of individual you choose as first alternate agent)  
-----  
-----  
(address) (city) (state) (zip code)  
-----  
(home phone) (work phone)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

-----  
(Name of individual you choose as second alternate agent)  
-----  
-----  
(address) (city) (state) (zip code)  
-----  
(home phone) (work phone)

(2) **AGENT'S AUTHORITY:** My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, **except** as I state here: My agent shall take any decision regarding my health on the basis of the Islamic principles. According to these principles life is invaluable. These principles require the provision of health care as long as there is the slightest hope of life in the body, they also require minimization of pain.

If at any time I should have a terminal condition and permanently unconscious state and two physicians, one of them may be my attending physician and the other should be specialized in the area of my illness or injury, determine that there can be no recovery from such condition and my death is imminent and the application of life-prolonging

procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld and/or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain.

I do desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to artificially prolong the process of dying.

If two physicians determine that my brain died, any blood circulation or life prolonging procedures must be withdrawn unless they are needed for the implementation of Part 2 of this Advance Health Care Directive.

**(ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4 5, OR 6 THAT DO NOT REFLECT YOUR WISHES)**\_\_\_\_\_

\_\_\_\_\_  
(Add additional sheets if needed.)

**(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

**(4) AGENT'S OBLIGATION:** My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Parts 1 and 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider the basic tenets and principles of Islam and the Islamic Law (Shari'ah).

**(5) AGENT'S POSTDEATH AUTHORITY:** My agent is authorized to make anatomical gifts, authorize an autopsy, and direct my funeral and burial, except as I state here or in Part 2 of this form:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(6) NOMINATION OF CONSERVATOR:** If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

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## PART 2

### DONATION OF ORGANS AT DEATH (OPTIONAL)

(7) Upon my death: (mark applicable box)

(a) Except for Testicles/Ovary and Penis/Vagina, I give any needed organs, tissues, or parts,

**OR**

(b) I give the following organs, tissues, or parts only: \_\_\_\_\_

(c) My gift is for the following purposes: (strike any of the following you do not want)

(1) Transplant

(2) Therapy

(3) Research

(4) Education

## PART 3

### PRIMARY PHYSICIAN (OPTIONAL)

(8) I designate the following physician as my primary physician:

\_\_\_\_\_  
(name of physician) (phone)

\_\_\_\_\_  
(address) (city) (state) (zip code)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

\_\_\_\_\_  
(name of physician) (phone)

\_\_\_\_\_  
(address) (city) (state) (zip code)

(9) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

(10) **SIGNATURE:** Sign and date the form here:

\_\_\_\_\_  
(date) (sign your name)

\_\_\_\_\_  
(address) (print your name)

\_\_\_\_\_  
(city) (state)

(11) **WITNESSES AND NOTARIZATION:**

(This advance health care directive will not be valid for making health care decisions unless it is either: (1) Signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (2) Acknowledged before a notary public).

**ALTERNATIVE NO. 1**

**STATEMENT OF WITNESSES**

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud or undue influence, (4) that I am not a person appointed as an agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individuals' health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

First Witness:

\_\_\_\_\_  
(date) (signature of witness)  
\_\_\_\_\_  
(address) (printed name of witness)  
-----  
(city) (state)

Second Witness:

\_\_\_\_\_  
(date) (signature of witness)  
\_\_\_\_\_  
(address) (printed name of witness)  
-----  
(city) (state)

**ALTERNATIVE NO. 2**

**NOTARY PUBLIC**

State of California

County of \_\_\_\_\_ )

On \_\_\_\_\_ before me, \_\_\_\_\_  
(insert name of notary public)

personally appeared \_\_\_\_\_,  
(insert the name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

NOTARY SEAL

\_\_\_\_\_  
(signature of notary)

**THIS SECTION IS TO BE COMPLETED ONLY IF YOU ARE A RESIDENT IN A SKILLED NURSING FACILITY**

**STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN**

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as witness as required by section 4675 of the Probate Code.

_____	_____
(date)	(signature)
_____	_____
(address)	(printed name)
-----	-----
(city)	(state)