North Dakota Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will (Health Care Instructions)
[ ] Appointment of Health Care Agent
[ ] Designation of Primary Physician
[ ] Organ Donation

I understand this document allows me to do ONE OR ALL of the following:

PART I: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make and communicate decisions for myself. AND/OR

PART II: Name another person (called the health care agent) to make health care decisions for me if I am unable to make and communicate health care decisions for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part I), if any, the wishes I have made known to him or her, or my agent must act in my best interest if I have not made my health care wishes known. AND/OR

PART III: Designate the doctor that I wish to be considered my primary physician (and, if desired an alternate choice if my primary doctor is unavailable). AND/OR

PART IV: Allows me to make an organ and tissue donation upon my death by signing a document of anatomical gift.

Part I: Living Will (Health Care Instructions)

NOTE: Complete this Part I if you wish to give health care instructions. If you appointed an agent in Part II, completing this Part I is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part II, you MUST complete, at a minimum, Part I (B) if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to make and communicate health care decisions for myself. These instructions must be followed (so long as they address my needs).

(A) THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

(I know I can change these choices or leave any of them blank)

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care:

My fears about my health care:

My spiritual or religious beliefs and traditions:

My beliefs about when life would be no longer worth living:

My thoughts about how my medical condition might affect my family:

(B) THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

(I know I can change these choices or leave any of them blank) Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help. I have these views about my health care in these situations:
(Note: You can discuss general feelings, specific treatments, or leave any of them blank).

If I had a reasonable chance of recovery and were temporarily unable to make and communicate health care decisions for myself, I would want:

If I were dying and unable to make and communicate health care decisions for myself, I would want:

If I were permanently unconscious and unable to make and communicate health care decisions for myself, I would want:

If I were completely dependent on others for my care and unable to make and communicate health care decisions for myself, I would want:

In all circumstances, my doctors will try to keep me comfortable and reduce my pain.

This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:

There are other things that I want or do not want for my health care, if possible:

Where I would like to live to receive health care:

Where I would like to die and other wishes I have about dying:

My wishes about what happens to my body when I die (cremation, burial):

Any other things:

(THIS HEALTH CARE DIRECTIVE WILL NOT BE VALID UNLESS IT IS NOTARIZED OR SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS HEALTH CARE DIRECTIVE.)

Part II: Appointment of Health Care Agent

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS FOR MYSELF
(I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent)
NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you

may leave Part II blank and go to Part III and/or Part IV. None of the following may be designated as your agent: your treating health care provider, a nonr-relative employee of your treating health care provider, an operator of a long-term care facility, or a non-relative employee of a long-term care facility.

When I am unable to make and communicate health care decisions for myself, I trust and appoint _____ (name)
to make health care decisions for me. This person is called my health care agent.
Relationship of my health care agent to me: _____
Telephone number of my health care agent: _____
Address of my health care agent: _____

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint:
_____ (name)
to be my health care agent instead.
Relationship of my alternate health care agent to me: _____
Telephone number of my alternate health care agent: _____
Address of my alternate health care agent: _____

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS FOR MYSELF
(I know I can change these choices)
My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to make and communicate health care decisions for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive and deciding about mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

[ ] (1) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

[ ] (2) To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

Part III: Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: 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)
_____ (address)
_____(phone).

Part IV: Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will (Health Care Instructions)
[ ] Appointment of Health Care Agent
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT. I HAVE READ A WRITTEN EXPLANATION OF THE NATURE AND EFFECT OF AN APPOINTMENT OF A HEALTH CARE AGENT THAT IS PART OF MY HEALTH CARE DIRECTIVE.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____

On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care, or have any claim against the declarant. The first witness is not a health care provider or long-term provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Appointment of Health Care Agent

I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapacitated. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner. If I choose to withdraw during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is not able to make health care decisions, I must notify the principal's physician.

Signature of Health Care Agent _____ Date _____

I accept my appointment :

Signature of Alternate Health Care Agent_____ Date _____