South 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 Declaration
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will Declaration

This is an important legal document. A living will directs the medical treatment you are to receive in the event you are in a terminal condition and are unable to participate in your own medical decisions. This living will may state what kind of treatment you want or do not want to receive. Prepare this living will carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes. This living will remains valid and in effect until and unless you revoke it. Review this living will periodically to make sure it continues to reflect your wishes. You may amend or revoke this living will at any time by notifying your physician and other health care providers. You should give copies of this living will to your family, your physician, and your health care facility. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected, and a notary public.

TO MY FAMILY, HEALTH CARE PROVIDER, AND ALL THOSE CONCERNED WITH MY CARE: I direct you to follow my wishes for care if I am in a terminal condition, my death is imminent, and I am unable to communicate my decisions about my medical care. With respect to any life-sustaining treatment, I direct the following: (**Initial only one of the following options. If you do not agree with either of the first two options, space is provided below, in the third option, for you to write your own instructions.)**

[ ] If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

[ ] Even if my death is imminent or I am permanently unconscious, I choose to prolong my life.

[ ] I choose neither of the above options, and here are my instructions should I become terminally ill and my death is imminent or I am permanently unconscious: **(Insert instructions)**

Artificial Nutrition and Hydration: food and water provided by means of a tube inserted into the stomach or intestine or needle into a vein. With respect to artificial nutrition and hydration, I Direct the following: **(Initial only one)**

[ ] If my death is imminent or I am permanently unconscious, I do not want artificial nutrition and hydration. If it has been started, stop it.

[ ] Even if my death is imminent or I am permanently unconscious, I want artificial nutrition and hydration.

Selection of Health Care Agent (Durable Power of Attorney for Health Care)

I hereby appoint ____ (name),
of ____ (address),
as my attorney-in-fact to consent to, reject, or withdraw consent for medical procedures, treatment, or intervention.

OPTIONAL: 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 alternate agent:
____________________________________ (name of individual you choose as alternate agent)
____ (address)

I have discussed my wishes with my attorney-in-fact and my alternate attorney-in-fact, and authorize him or her to make all and any health care decisions for me, including decisions to withhold or withdraw any form of life support. I expressly authorize my agent to make decisions for me regarding the withholding or withdrawal of artificial nutrition and hydration in all medical circumstances.

This power of attorney becomes effective when I can no longer make my own medical decisions and is not affected by physical disability or mental incompetence. The determination of whether I can make my own medical decisions is to be made by my attorney-in-fact, or if he or she is unable, unwilling, or unavailable to act, by my alternate attorney-in-fact, unless the attending physician determines that I have the capacity to make my own decisions.

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).

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 Declaration

[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)

[ ] Designation of Primary Physician

[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

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 or attorney-in-fact 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. I am not a health care 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 Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care:

Signature ______________________________ Date ____________________

I accept my appointment as Alternate Health Care Agent and Attorney-in-Fact for Health Care:

Signature ______________________________ Date ____________________