NORTH DAKOTA HEALTH CARE DIRECTIVE

NAME:____ **DOB:**______________________

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

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

AND/OR

PART II: 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 decisions for myself.

AND/OR

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

PART I: APPOINTMENT OF HEALTH CARE AGENT

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS
FOR ME IF I AM UNABLE TO DECIDE OR SPEAK 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 I blank and go to Part II and/or Part III.

When I am unable to decide or speak for myself, I trust and appoint________________________

______________ 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 readily available, I trust and appoint__________________________

________________________ to be my health care agent instead.

Relationship of my alternative health care agent to me:________________________________

Telephone number of my alternative health care agent:________________________________

Address of my alternative health care agent:____

____

PATIENT LABEL
OR

PATIENT NAME:________________________________

PATIENT DOB:_________________________________

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK 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.

My health care agent has the power to:

(A) Make any health care decisions 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.

I want my agent to start making medical decisions for me:

_____ Immediately, even though you still have the capacity to make decisions for your own healthcare, or
_____ When you have become incapacitated.

PART II: HEALTH CARE INSTRUCTIONS

NOTE: Complete this PART II if you wish to give health care instructions. If you appointed an agent in PART I, completing this PART II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in PART I, you **MUST** complete some or all of this PART II if you wish to make a valid health care directive.

This is an important legal document about life-prolonging treatment and nutrition and hydration. This document becomes effective only when you are terminally ill.

A. I have made the following decision concerning life-prolonging treatment (initial 1, 2, or 3):

1. (_____) I direct that life-prolonging treatment <u>be withheld or withdrawn</u> and that I be permitted to <u>die naturally</u> if two physicians certify that:
   (a) I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death;
   (b) The application of life-prolonging treatment would serve only to artificially prolong the process of my dying; and
   (c) I am not pregnant.

   It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and that they accept the consequences of my refusal, which is death.

2. (____) I direct that life-prolonging treatment, which could extend my life, <u>be used</u> if two physicians certify that I am in a terminal condition that is an incurable or irreversible

condition which, without the administration of life-prolonging treatment, will result in my imminent death. It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to direct that medical or surgical treatment be provided.

3. (____) I make no statement concerning life-prolonging treatment.

B. I have made the following decision concerning the administration of nutrition when my death is imminent (initial only one statement):

1. (____) I wish to receive nutrition.
2. (____) I wish to receive nutrition unless I cannot physically assimilate nutrition, nutrition would be physically harmful or cause unreasonable physical pain, or nutrition would only prolong the process of my dying.
3. (____) I do not wish to receive nutrition.
4. (____) I make no statement concerning the administration of nutrition.

C. I have made the following decision concerning the administration of hydration when my death is imminent (initial only one statement):

1. (____) I wish to receive hydration.
2. (____) I wish to receive hydration unless I cannot physically assimilate hydration, hydration would be physically harmful or would cause unreasonable physical pain, or that hydration would only prolong the process of my dying.
3. (____) I do not wish to receive hydration.
4. (____) I make no statement concerning the administration of hydration.

D. Concerning the administration of nutrition and hydration, I understand that if I make no statement about nutrition or hydration, my attending physician may withhold or withdraw nutrition or hydration if the physician determines that I cannot physically assimilate nutrition or hydration or that nutrition or hydration would be physically harmful or would cause unreasonable physical pain.

E. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration is not effective during the course of my pregnancy.

F. I understand the importance of this declaration, I am voluntarily signing this declaration, I am at least eighteen years of age, and I am emotionally and mentally competent to make this declaration.

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

H. I understand that I may revoke this declaration at any time.

I. Special Requests:____

____

PATIENT LABEL
OR

PATIENT NAME:________________________________

PATIENT DOB:________________________________

PART III: MAKING AN ANATOMICAL GIFT

I would like to be an organ and tissue donor at the time of my death. I have told my family my decision and ask my family to honor my wishes. I wish to donate the following: (initial statement)

_____ Any appropriate organs ☐ Yes ☐ No

_____ Any appropriate tissues ☐ Yes ☐ No

PART IV: MAKING THE DOCUMENT LEGAL PRIOR DESIGNATIONS REVOKED.

I revoke any prior health care directive.

DATE AND SIGNATURE OF DOCUMENT OWNER
(YOU MUST DATE AND SIGN THIS HEALTH CARE DIRECTIVE)

I sign my name to this Health Care Directive Form on____________________________________
(Date)

at____
(City) (State) (Zip)

____
(You sign here)

(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.)

NOTARY PUBLIC OR STATEMENT OF WITNESSES

This document must be (1) notarized or (2) witnessed by two qualified adult witnesses. The person notarizing this document may be an employee of a health care or long-term care provider providing you care. At least one witness to the execution of the document must not be a health care or long-term care provider providing you with direct care or an employee of the health care or long-term care provider providing you with direct care.

None of the following may be used as a notary or witness:

1. A person you designate as your agent or alternate agent;
2. Your spouse;
3. A person related to you by blood, marriage, or adoption;
4. A person entitled to inherit any part of your estate upon your death;
5. A person who has, at the time of executing this document, any claim against your estate.

Option 1: Notary Public

In my presence on ________________________(date),____ (name of witness) acknowledged the document owner's signature on this document or acknowledged that the document owner directed the person signing this document to sign on the document owner's behalf.

____ (Signature of Notary Public)

_____________________20________ My commission expires

Option 2: Two Witnesses

Witness One:

(1) In my presence on ________________________(date),_______________________________________ (name of witness) acknowledged the document owner's signature on this document or acknowledged that the document owner directed the person signing this document to sign on the document owner's behalf.

(2) I am at least eighteen years of age.

(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box. [ ]

I certify that the information in (1) through (3) is true and correct.

____ (Signature of Witness One)

____

____ (Address)

PATIENT LABEL
OR
PATIENT NAME:______________________________
PATIENT DOB:______________________________

Witness Two:

(1) In my presence on ______________(date),___________________________ (name of witness) acknowledged the document owner's signature on this document or acknowledged that the document owner directed the person signing this document to sign on the document owner's behalf.

(2) I am at least eighteen years of age.

(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box. [ ]

I certify that the information in (1) through (3) is true and correct.

____
(Signature of Witness Two)

____

____
(Address)

ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY

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 document owner as expressed in this appointment. I understand that this document gives me authority over health care decisions for the document owner. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the document owner may revoke this power of attorney at any time in any manner.

If I choose to withdraw during the time the document owner is competent, I must notify the document owner of my decision. If I choose to withdraw when the document owner is not able to make health care decisions, I must notify the document owner's physician.

____
(Signature of Agent/Date)

____
(Signature of Alternative Agent/Date)

STATEMENT AFFIRMING EXPLANATION OF DOCUMENT TO RESIDENT OF LONG-TERM CARE FACILITY.

(Only necessary if person is a resident of long-term care facility and Part I is completed appointing an agent. This statement does not need to be completed if the resident has read a written explanation of the nature and effect of an appointment of a health care agent and completed the Principal's Statement above.)

I have explained the nature and effect of this health care directive to ____________________

_____________________ who is a resident of ____

__________________________ (name and city of facility). I am (check one of the following):

A recognized member of the clergy.

An attorney licensed to practice in North Dakota.

A person designated by the District Court for the County in which the above-named facility is located.

A person designated by the North Dakota Department of Human Services.

Dated on ______________________, 20_____.   ____
(Signature)

STATEMENT AFFIRMING EXPLANATION OF DOCUMENT TO HOSPITAL PATIENT OR PERSON BEING ADMITTED TO HOSPITAL.

(Only necessary if person is a patient in a hospital or is being admitted to a hospital and Part I is completed appointing an agent. This statement does not need to be completed if the patient or person being admitted has read a written explanation of the nature and effect of an appointment of a health care agent and completed the Principal's Statement above.)

I have explained the nature and effect of this health care directive to ____________________ __________________________(name of declarant) who signed this document and who is a patient or is being admitted as a patient of Trinity Hospitals in Minot, North Dakota.

I am (check one of the following):

An attorney licensed to practice in North Dakota.

A person designated by the hospital to explain the health care directive.

Dated on ______________________, 20_____.   ____
(Signature)

PATIENT LABEL
OR
PATIENT NAME:_______________________________
PATIENT DOB:________________________________