Legal Forms & Services

FirstName LastName

SOUTH DAKOTA HEALTH CARE DIRECTIVE

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive in South Dakota
After printing your document, you will need to finalize it. Below are the steps:

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses and a notary
3. Have witnesses sign and date
4. Have notary sign and date
5. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive. Review your state's laws on witness requirements for health care directives.

LIVING WILL

FOR

FirstName LastName

This document includes the following:

> Living will declaration with health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.
>
> Power of attorney for health care designating a health care attorney-in-fact to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my attorney-in-fact should act in my best interest.

LIVING WILL DECLARATION

TO MY FAMILY, HEALTH CARE PROVIDER, AND ALL THOSE CONCERNED WITH MY CARE:

I, FirstName LastName, 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 following options, space is provided below 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:

Artificial Nutrition & 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.

POWER OF ATTORNEY FOR HEALTH CARE

I, FirstName LastName, being an adult of sound mind, instruct the following pursuant to the laws of South Dakota.

PRIMARY HEALTH CARE ATTORNEY-IN-FACT. If I am unable to make or communicate health care decisions for myself, I name the following individual to make health care decisions for me:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, South Dakota 11111

Phone: 1111111111

Email: emailaddress@email.com

ALTERNATE HEALTH CARE ATTORNEY-IN-FACT. If my primary attorney-in-fact is not willing, able, or reasonably available, I name the following individual to make health care decisions for me:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, South Dakota 11111

Phone: 1111111111

Email: emailaddress@email.com

AUTHORITY OF HEALTH CARE ATTORNEY-IN-FACT. My attorney-in-fact may make any health care decisions for me which I could make individually if I had decisional capacity. All decisions should be made in accordance with accepted medical standards. When making my health care decisions, my attorney-in-fact should consider the recommendation of my attending physician, the decisions that I would have made if I had decisional capacity, if known, and decision that would be in my best interest.

Limitations on Attorney-in-Fact's Authority:

I do not wish to limit the authority of my health care attorney-in-fact at this time.

SIGNATURES

This document must be signed and dated by me. It also must be verified by two witnesses and signed and dated when it is witnessed. It may be acknowledged by a notary public.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: ______________________________

Date signed: _______________________________

If I cannot sign my name, I ask the below named person to sign for me.

Signature: _________________________________

Printed Name:______________________________

TWO WITNESSES

Witness One. In my presence on ___________________________ (date), FirstName LastName (name) voluntarily acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf.

Witness One Signature: _____________________________

Witness One Printed Name: _________________________

Witness One Address: ______________________________

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Witness One Phone: ________________________________

Witness Two. In my presence on ___________________________ (date), FirstName LastName (name) voluntarily acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf.

Witness Two Signature: ____________________________

Witness Two Printed Name: _________________________

Witness Two Address: ______________________________

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Witness Two Phone: _______________________________

NOTARY PUBLIC (OPTIONAL)

In my presence on ___________________________ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf.

Notary Public Signature: __________________________________

Commission Expiration Date: ______________________________