FirstName LastName

NORTH 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 North Dakota

After printing your document, you will need to finalize it. Below are the steps:

Option 1: Witnesses Only

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

Option 2: Notary Only

1. Print out your document
2. Review, initial, sign, and date in front of a notary
3. Have notary sign and date
4. 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

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

PART I: Name another individual (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 II), 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 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 and communicate decisions for myself.

AND/OR

PART III: Make an organ and tissue donation upon my death by signing a document of anatomical gift.

PART I: APPOINTMENT OF HEALTH CARE AGENT

When I am unable to make and communicate health care decisions for myself, I trust and appoint the following individual as my health care agent to make health decisions for me:

Name:	FirstName LastName
Relationship:	Spouse
Address:	111 Street Address
	City, North Dakota 11111
Phone:	1111111111
Email:	emailaddress@email.com

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint the following individual to be my health care agent instead:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, North Dakota 11111

Phone: 1111111111

Email: emailaddress@email.com

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

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:

I do not wish to limit the authority of my health care agent at this time.

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).

PART II: HEALTH CARE INSTRUCTIONS

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

My goals for my health care: I do not wish to state my goals at this time.

My fears about my health care: I do not wish to state my fears at this time.

My spiritual or religious beliefs and traditions: I do not wish to state my beliefs and traditions at this time.

My beliefs about when life would be no longer worth living: I do not wish to state my beliefs at this time.

My thoughts about how my medical condition might affect my family: I do not wish to state my thoughts at this time.

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

I have these views about my health care in these situations.

If I had a reasonable chance of recovery and were temporarily unable to make and communicate health care decisions for myself, I would want: I do not wish to state my views at this time.

If I were dying and unable to make and communicate health care decisions for myself, I would want: I do not wish to state my views at this time.

If I were permanently unconscious and unable to make and communicate health care decisions for myself, I would want: I do not wish to state my views at this time.

If I were completely dependent on others for my care and unable to make and communicate health care decisions for myself, I would want: I do not wish to state my views at this time.

In all circumstances, my health care providers 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: I do not wish to state my feelings about pain relief at this time.

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

Who I would like to be my health care provider: I do not wish to name a health care provider at this time.

Where I would like to live to receive health care: I do not wish to state where I would like to live at this time.

Where I would like to die and other wishes I have about dying: I do not wish to state wishes about dying at this time.

My wishes about what happens to my body when I die (burial, cremation): I do not wish to state my wishes about what happens to my body when I die at this time.

Any other things: I do not wish to state any other wishes at this time.

PART III: MAKING AN ANATOMICAL GIFT

_____☑ I WANT TO BE AN ORGAN DONOR
I would like to be an organ 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 any needed organs and tissue.

PART IV: MAKING THE DOCUMENT LEGAL

EARLIER DESIGNATIONS REVOKED. I revoke any earlier health care directive.

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS HEALTH CARE DIRECTIVE)

I sign and date this health care directive on _____ (date) at:

_____
(City)

_____
(State)

_____

(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 individual notarizing this document may be an employee of a health care or long-term care provider providing your care. At least one witness to the execution of the document may 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. An individual you designate as your agent or alternate agent;
2. Your spouse;
3. An individual related to you by blood, marriage, or adoption;
4. An individual entitled to inherit any part of your estate upon your death; or
5. An individual who has, at the time of executing this document, any claim against your estate.

Option 1: Notary Public

State of _____

County of _____

In my presence on _____ (date), FirstName LastName (declarant's name) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the individual signing this document to sign on the declarant's behalf.

_____
Signature of Notary Public

My commission expires on _____, 20___.

I, _____ (health care agent name), sign this directive and understand my acceptance grants authority to me to make health care decisions on behalf of FirstName LastName at such time as the principal becomes incapacitated.

Option 2: Witnesses

Witness One:

1) In my presence on _____ (date), _____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the individual signing this document to sign on the declarant'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 on this line: _____.

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

_____
(Signature of Witness One)

_____
(Printed Name)

_____

_____
(Address)

Witness Two:

1) In my presence on _____ (date), _____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the individual signing this document to sign on the declarant'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 on this line: _____.

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

_____
(Signature of Witness Two)

_____
(Printed Name)

_____

_____
(Address)

PRINCIPAL'S STATEMENT

I have read a written explanation of the nature and effect of an appointment of a health care agent which is attached to my health care directive.

Dated this ___ day of _____ , 20___.

_____
(Signature of Principal)