

## DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, “the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a ‘scientific’ process.” Because of “political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective” (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that “The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow,” and suggesting that revised and enhanced documents “may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes” (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

*Lifecare Directives* staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic professionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or “health care instruction” or “declaration”) and medical power of attorney (or “proxy”) forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, “*Should I Use a Shorter Standard Directive?*” available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~



*Statutory  
Advance Directive  
For  
New Hampshire Residents*



*Statutory Compliant  
Advance Directive for  
Health Care Choices*



~ Lifecare Directives ~



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***Important Notice:***

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warranted to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

# Statutory Advance Directive For New Hampshire Residents

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Print Full Name

Date of Birth

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**Your right** (when age 18 or older): To Document Your Personal Wishes,  
and to have these wishes followed ~~

The New Hampshire legislature has provided statutes guiding the construction of both a Living Will and a Power of Attorney for Health Care, for use by the general public. Collectively, these documents are known as “advance directives.” As the content of these documents was designed by your state government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

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## ***Understanding Your Directive***

To make the *best* choices for your medical care, your physician needs to know your wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at **any** time by: **1)** writing “revoked” across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2)** by completing a Notice of Revocation; or **3)** by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4)** by *simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed after your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing “deleted” beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless

you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

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***Instructions for Completing the Directive:***

This directive is written in two parts. While it is **best** if you fill out the whole document, you may choose to complete only **Section I**, leaving just a statement of your values and wishes. Or you may complete only **Section II**, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should **initial** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write “No,” “None,” or “Does Not Apply” in areas that would otherwise be left blank.

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**SECTION I:**  
**LIVING WILL DECLARATION**  
***and Personal Instructions***

*(NHR Title X: Ch.137-H:§137-H:1 to §137-H:16)*

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1. Introduction: *A person of sound mind who is 18 years of age or older may execute at any time a document commonly known as a living will, directing that no life-sustaining procedures be used to prolong his life when he is in a terminal condition or is permanently unconscious. The document shall only be effective if the person is permanently incapable of participating in decisions about his care, and it may be, but need not be, in form and substance substantially as follows:*

**DECLARATION**

2. Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.
3. I, \_\_\_\_\_, being of sound mind, do willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

**A. *Regarding Terminal and Permanently Unconscious Conditions:*** If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition or a permanently unconscious condition by 2 physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized, or that I will remain in a permanently unconscious condition, and where the use of life-sustaining treatments would serve only to make my dying take longer, I direct that life-sustaining treatments shall not be given, or shall be stopped, and that I be permitted to die naturally with

only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary to give me comfort care.

B. **Regarding Food and Fluid Through Tubes or Medical Devices.** I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial nutrition and hydration. In carrying out any instruction I have given under this section, I authorize that artificial nutrition and hydration not be started or, if started, be discontinued. *(Circle your choice and initial beside it. If you do not choose "yes," artificial nutrition and hydration will be provided and will not be removed.)*

\_\_\_\_\_ [yes];            \_\_\_\_\_ [no]

4. **Statement of Intent.** In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physicians as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

5. **Declaration of Understanding and Competence.** I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

6. Signed \_\_\_\_\_

State of New Hampshire

County of \_\_\_\_\_

***Statement of Witnesses***

7. We, the following witnesses, being duly sworn each declare to the notary public or justice of the peace or other official signing below as follows:

A. The declarant signed the instrument as a free and voluntary act for the purposes expressed, or expressly directed another to sign for him.

B. Each witness signed at the request of the declarant, in his presence, and in the presence of the other witness.

C. To the best of my knowledge, at the time of the signing the declarant was at least 18 years of age, and was of sane mind and under no constraint or undue influence.

8. Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

9. Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

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***NOTARIZATION:  
(Required)***

10. The affidavit shall be made before a notary public or justice of the peace or other official authorized to administer oaths in the place of execution, who shall not also serve as a witness, and who shall complete and sign a certificate in content and form substantially as follows:

11. Sworn to and signed before me by \_\_\_\_\_, declarant,  
and \_\_\_\_\_, and \_\_\_\_\_,  
witnesses, on the date of: \_\_\_\_\_.

*WITNESS my hand and official seal.*

\_\_\_\_\_  
Signature of Notary Public

**Notary Seal:**

\_\_\_\_\_  
Date Commission Expires

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**SECTION II:**  
**DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

*Designation of Health Care Agent*  
(NHRs Title X: Ch.137-J:§137-J:1 to §137-J:16)

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12. Introduction. *The disclosure statement which must accompany a durable power of attorney for health care must be in substantially the following form:*

**INFORMATION CONCERNING  
THE DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE**

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent, therefore, can have the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent cannot consent or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy unless the failure to withhold the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this document any treatment you do not desire, except as stated above, or treatment you want to be sure you receive. Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. If for moral or religious reasons you do not wish to be treated by a doctor or examined by a doctor for the certification that you lack capacity, you must say so in the document and name a person to be able to certify your lack of capacity. That person may not be your agent or alternate agent or any person ineligible to be your agent. You may attach additional pages if you need more space to complete your statement. If you want to give your agent authority to withhold or withdraw the artificial providing of nutrition and fluids, your document must say so. Otherwise, your agent will not be able to direct that. Under no conditions will your agent be able to direct the withholding of food and drink for you to eat and drink normally.

Your agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have had if made consistent with state law. It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not

understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust and must be at least 18 years old. If you appoint your health or residential care provider (e.g. your physician, or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person will have to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time. You should inform the person you appoint that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who will have signed copies. Your agent will not be liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing him or her or your health care provider orally or in writing. This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one.

You should consider designating an alternate agent in the event that your agent is unwilling, unable, unavailable, or ineligible to act as your agent. Any alternate agent you designate will have the same authority to make health care decisions for you.

**THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO (2) OR MORE QUALIFIED WITNESSES WHO MUST BOTH BE PRESENT WHEN YOU SIGN AND ACKNOWLEDGE YOUR SIGNATURE. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:**

- the person you have designated as your agent;
- your spouse;
- your lawful heirs or beneficiaries named in your will or a deed;

**ONLY ONE OF THE TWO WITNESSES MAY BE YOUR HEALTH OR RESIDENTIAL CARE PROVIDER OR ONE OF THEIR EMPLOYEES.**

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

13. Be it known that I,  
 Full Legal Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

~~ do hereby appoint:

14. **Name of Agent:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

~ as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document or as prohibited by law. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS  
REGARDING HEALTH CARE DECISIONS.

15. For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (*Life-sustaining treatment is defined as procedures without which a person would die, such as, but not limited to the following: cardiopulmonary resuscitation, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.*) There is also a section which allows you to set forth specific directions for these or other matters. If you wish you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

A. If I become permanently incompetent to make health care decisions, and if I am also suffering from a terminal illness, I authorize my agent to direct that life-sustaining treatment be discontinued. (*Circle your choice and initial beside it.*)

\_\_\_\_\_ [yes];          \_\_\_\_\_ [no]

B. Whether terminally ill or not, if I become permanently unconscious I authorize my agent to direct that life-sustaining treatment be discontinued. (*Circle your choice and initial beside it.*)

\_\_\_\_\_ [yes];          \_\_\_\_\_ [no]

C. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial feeding (artificial nutrition and hydration). In carrying out any instructions I have given above in A or B (above) or any instructions I may write in D below, I authorize my agent to direct that (*Circle your choice of (1) or (2) and initial beside it:*)

\_\_\_\_\_ 1) artificial feeding and hydration not to be started or, if started, be discontinued,

– **OR** –

\_\_\_\_\_ 2) although all other forms of life-sustaining treatment be withdrawn, but artificial feeding and hydration shall continue to be given to me.

*(I understand that if I do not complete item C, with a selection above, my agent will not have the power to stop artificial feeding and hydration.)*

D. I wish to be given medication which is necessary to control my pain regardless of any of the choices I have made above.

\_\_\_\_\_ yes; \_\_\_\_\_ no.

E. Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. You may leave this question blank if you desire.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(attach additional pages as necessary)*

16. In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

~~ as alternate agent.

17. I hereby acknowledge that I have been provided with the disclosure statement explaining the effect of this document. I have read and understand the information contained in the disclosure statement.

18. The original of this document will be kept at: \_\_\_\_\_

\_\_\_\_\_

~~ and the following persons and institutions will have signed copies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. In witness whereof, I have hereunto signed my name  
~~ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

20. **Signature** \_\_\_\_\_

21. I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

22. **1<sup>st</sup> Witness:** \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Name Printed) (Date)

\_\_\_\_\_  
(Residence Address)

23. **2<sup>nd</sup> Witness:** \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Name Printed) (Date)

\_\_\_\_\_  
(Residence Address)

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**Certificate of Acknowledgment of Notary Public:**

24. State of New Hampshire,

County of \_\_\_\_\_ }  
\_\_\_\_\_ }

The foregoing instrument was acknowledged before me on:

This \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

*WITNESS my hand and official seal:*

\_\_\_\_\_  
Notary Public / Justice of the Peace

**Seal:**

\_\_\_\_\_  
Date Commission Expires