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 processionals 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

North Dakota Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

North Dakota Residents

Statutory Compliant Advance Directive for Health Care Choices

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 warrantied 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 North Dakota Residents

________________________________ ________________________________

Print Full Name *Date of Birth*

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

The North Dakota legislature has provided statutes guiding the construction of both a Health Care Instruction (living will) and a Power of Attorney for Health Care for use by the 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 that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read it carefully to ensure that your advance directive is fully and properly filled out.

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.

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.

HEALTH CARE DIRECTIVE

Instructions and Appointment of Health Care Agent

(*Pursuant to NDCCode, Title 23; Ch.23-06.5: §23-06.5-01 to §23-06.5-18*)

(1) INTRODUCTION: *The following is an optional form of a health care directive and is not a required form.*

(2) Be it known that I:

Full Legal Name: ____

Date of Birth: ____

Street Address: ____

City: ________________________ County: _____________________

State: ________________________ Zip Code: ___________________

~~ understand this document allows me to do ONE OR ALL of the following:

(3) **PART I**: 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

(4) **PART II**: Name another person (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

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

(6) MY specific instructions, appointments, and other directions follow, below.

PART I: HEALTH CARE INSTRUCTIONS

NOTE: Complete this Part I if you wish to give health care instructions. If you intend to appoint an agent in Part II, completing this Part I is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part II, you MUST complete, at a minimum, Part I (B) if you wish to make a valid health care directive.

(7) 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:
(*I know I can change these choices or leave any of them blank*)

1. My goals for my health care: ____
____
____
____

2. My fears about my health care: ____
____
____
____

3. My spiritual or religious beliefs and traditions: ________________________________
____
____
____

4. My beliefs about when life would be no longer worth living: ____________________
____
____
____

5. My thoughts about how my medical condition might affect my family: ___________
____
____
____

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

(*I know I can change these choices or leave any of them blank*)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help. I have these views about my health care in these situations (*note – you can discuss general feelings, specific treatments, or leave any of them blank*):

1. If I had a reasonable chance of recovery and were temporarily unable to make and communicate health care decisions for myself, I would want: ______________________
____
____

2. If I were dying and unable to make and communicate health care decisions for myself, I would want: ____
____
____

3. If I were permanently unconscious and unable to make and communicate health care decisions for myself, I would want: ____
____
____
____

4. If I were completely dependent on others for my care and unable to make and communicate health care decisions for myself, I would want: ______________________
____
____
____

5. In all circumstances, my doctors 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: ____
____
____
____

6. There are other things that I want or do not want for my health care, if possible:
   a) Who I would like to be my doctor: ______________________________
   ____
   ____
   ____

   b) Where I would like to live to receive health care: ________________
   ____
   ____
   ____

   c) Where I would like to die and other wishes I have about dying: _________
   ____
   ____
   ____

   d) My wishes about what happens to my body when I die (cremation, burial):
   ____
   ____
   ____

   e) Any other things: ____
   ____
   ____
   ____

PART II:
APPOINTMENT OF HEALTH CARE AGENT

(8) THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS 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 II blank and return to Part I and/or go on to Part III.

None of the following may be designated as your agent: your treating health care provider, a non-relative employee of your treating health care provider, an operator of a long-term care facility, or a non-relative employee of a long-term care facility.

(9) If I am unable to make or communicate health care decisions for myself, I trust and appoint:

Name of Agent: ____
Relationship of my health care agent to me: __________________________
Address: ____
Telephone: Home:____________________ Work:_____________________
Cell Phone or Pager: __________________ E-mail: ___________________

~~ to make health care decisions for me. This person is called my health care agent.

(10) (*OPTIONAL*) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my health care agent is not reasonably available, I trust and appoint:

Name of Alternate:____
Relationship of my health care agent to me: __________________________
Address: ____
Telephone: Home:____________________Work:_____________________
Cell Phone or Pager: __________________ E-mail: ____________________

~~ to be my health care agent instead.

(11) 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 (*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. 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.

(12) 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:

____
____
____
____

(13) My health care agent is NOT automatically given the powers listed below, in (A) and (B). If I WANT my agent to have any of the powers in (A) and (B), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

_____(A) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

_____(B) To decide what will happen with my body when I die (burial, cremation). If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here: ____
____
____
____

PART III:
MAKING AN ANATOMICAL GIFT

(14) 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 only one statement*):

[_____] Any needed organs and tissue.

[_____] Only the following organs and tissues: __________________________
____

[_____] No organs or tissues.

PART IV:
MAKING THE DOCUMENT LEGAL

(15) PRIOR DESIGNATIONS REVOKED. I revoke any prior health care directive.

(16) DATE AND SIGNATURE OF PRINCIPAL (*YOU MUST DATE AND SIGN THIS HEALTH CARE DIRECTIVE*)

(17) Being of sound mind, and acting without duress, coercion, or undue influence, I sign my name to this Health Care Directive Form on the date and at the place indicated below:

____
(you sign here)

____
(date)

____
(city)

____
(state)

(*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*.)

(18) 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 your 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:

a. A person you designate as your agent or alternate agent;
b. Your spouse;
c. A person related to you by blood, marriage, or adoption;
d. A person entitled to inherit any part of your estate upon your death; or
e. A person who has, at the time of executing this document, any claim against your estate.

(19) **Option 1**: Notary Public
In my presence on the _________ day of, ______________________, in the year _____, (*name of declarant*) ____acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

____
(*Signature of Notary Public*)

My commission expires: __________________________ , 20______.

(20) **Option 2**: Two Witnesses

Witness One:

(1) In my presence on the ________ day of, ____________________, in the year _____, (name of declarant) ____ acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person 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 this box: [______].

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

____

(*Signature of Witness One*)

____

(*Printed Name*)

____

(*Address*)

Witness Two:

(1) In my presence on the ________ day of, ____________________, in the year _____, (name of declarant) ____ acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person 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 this box: [______].

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

____

(*Signature of Witness One*)

____

(*Printed Name*)

____

(*Address*)

(21) 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 principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapacitated. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any

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

____

(*Signature of agent/date*)

____

(*Signature of alternate agent/date*)

(22) PRINCIPAL'S STATEMENT. I have read a written explanation of the nature and effect of an appointment of a health care agent that is attached to my health care directive.

Dated this ________ day of, ____________________________, in the year _______,

____

(Signature of Principal)

(23) 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 II 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.*)

(24) I have explained the nature and effect of this health care directive to (*name of principal*): ______________________________________ who signed this document and who is a resident of (*name and city of facility*) _______________________________________.

(25) I am (*initial* <u>*one*</u> *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 this ____________day of, _____________________________, 20______.

____

(*Signature*)

(26) 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 II 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.*)

(27) I have explained the nature and effect of this health care directive to (*name of principal*): _______________________________________ who signed this document and who is a resident of (*name and city of facility*) _______________________________________.

(28) I am (initial 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 this ____________day of, ______________________________, 20______.

____
(*Signature*)