Making Health Care Decisions in North Dakota:

A Summary of North Dakota Law Regarding

Health Care Directives

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INTRODUCTION

The Patient Self-Determination Act is a federal law that requires health care providers to educate their patients and the community on issues related to advance directives.

It requires hospitals, nursing facilities, hospices, home health agencies, and Health Maintenance Organizations (HMO's) certified by Medicare and Medicaid to furnish written information so that patients have the opportunity to express their wishes regarding the use or refusal of medical care, including life-prolonging treatment, nutrition, and hydration.

The federal law takes no stand on what decisions persons should make. It does not require persons to execute an advance directive.

This booklet was developed by the Aging Services Division of the North Dakota Department of Human Services to provide you with a written summary of North Dakota law regarding advance directives and health care decision-making authority. It is not intended to provide specific legal advice regarding these matters, therefore any specific questions should be addressed to an attorney.

As a competent adult, you have the right to control decisions about your own health care. You have the right to accept or to refuse any treatment, service, or procedure used to diagnose, treat, or care for your physical or mental condition.

You have the right to make your own health care decisions as long as you have the ability to:

1. Understand and appreciate the nature and consequences of a health care decision; and

2. Communicate a health care decision.

Your right to decide includes the right to control the use of medical technology in regard to your health care. Part of your right to make your

own medical decisions is your right to decide, based upon your values, the extent to which medical technology should be used and under what circumstances.

Your right to decide also includes the right to make decisions regarding the artificial giving of food and water (nutrition and hydration).

TO EXERCISE YOUR RIGHT TO MAKE YOUR OWN MEDICAL DECISIONS, YOU SHOULD DO THE FOLLOWING:

1. Make certain you understand your medical treatment options. If you do not understand something or need more information, ask your health care provider or providers. You have the right to an explanation in terms that you understand.

2. If you have ethical or moral concerns about your decisions you should speak to your minister, rabbi, or other advisor, or perhaps members of your family or a close friend.

3. Discuss your desires with your doctor or health care provider. Make sure that your health care provider understands what you want in the event you are unable to make your own medical decisions.

There may come a time when, due to your mental or physical condition, you may be unable to make your own health care decisions. Then your health care providers will look to any prior written advance directives or to family members to make decisions on your behalf. A doctor must make a determination that you are unable to make your own health care decisions.

An optional advance directive form was created by the North Dakota legislature, which can be found beginning on page 21 of this guide. The advance directive form is called a “health care directive,” where you either state choices for medical treatment or designate who should make treatment choices if you are unable to make treatment choices or communicate. Other common terms for the health care directive include “living will” or “durable power of attorney for health care.”

HEALTH CARE DIRECTIVES

The North Dakota law regarding “health care directives” is found in Chapter 23-06.5 of the North Dakota Century Code.

A health care directive is a legal document that permits you to:

1. Give instructions about any aspect of your health care.

2. Choose a person to make health care decisions for you.

3. Give instructions about specific medical treatments you do or do not want.

4. Give other instructions, including where you wish to die.

5. Make an anatomical gift.

Your decision to complete a health care directive is personal and should be based upon your individual values and beliefs.

To complete a health care directive, it must:

1. Be in writing;

2. Be dated;

3. State the name of the person to whom it applies;

4. Be executed by a person with the capacity to understand, make and communicate decisions;

5. Be signed by a person to whom it applies or by another person authorized to sign on behalf of the person to whom it applies;

6. Contain verification of the required signature, either by a notary public or by qualified witnesses; and

7. Include a health care instruction or a power of attorney for health care, or both.

You should provide a copy of your health care directive to your doctor and any other health care providers such as your hospital, nursing facility, hospice, or home health agency. In addition, you may want to give copies of your health care directive to other persons, such as close family members and your attorney, if you have one.

If you choose to execute a health care directive, you may use the optional legal form found in North Dakota Century Code chapter 23-06.5, and beginning on page 21 of this guide.

QUESTIONS AND ANSWERS – HEALTH CARE DIRECTIVES

This section includes a number of commonly asked questions and their answers regarding health care directives.

1. WHAT IS A HEALTH CARE DIRECTIVE?

A health care directive is a written declaration that allows you to:

1) Give instructions about any aspect of your health care.

2) Choose a person to make health care decisions for you.

3) Give instructions about specific medical treatments you do or do not want.

4) Give other instructions, including where you wish to die.

5) Make an anatomical gift.

2. WHO CAN MAKE A HEALTH CARE DIRECTIVE?

Any competent person 18 years of age or older.

3. DOES A HEALTH CARE DIRECTIVE NEED TO BE WITNESSED OR NOTARIZED?

A health care directive must contain verification of your signature, or the signature of the person authorized by you to sign on your behalf, either by a notary public or two witnesses who are at least eighteen years of age.

The witnesses or notary to your health care directive <u>cannot</u> be:

1) You;

2) Your spouse;

3) Related to you by blood, marriage, or adoption;

4) Entitled to inherit any part of your estate upon your death; or

5) Claimants to any portion of your estate.

4. DOES A HEALTH CARE DIRECTIVE NEED TO BE IN WRITING?

Yes. To be legally sufficient in North Dakota, a health care directive must be in writing.

5. HOW DO I KNOW THAT MY WISHES WILL BE CARRIED OUT?

Your doctor or health care provider is responsible for ensuring that your wishes are carried out. If your doctor or health care provider is unwilling to comply with your wishes, then he or she must notify the agent of their unwillingness to comply, document the notification in your medical record, and take all reasonable steps to transfer your care to another doctor or health care provider who is willing to comply.

6. CAN I REVOKE MY HEALTH CARE DIRECTIVE?

Yes. As long as you remain competent you can revoke your health care directive in any one of three ways:

1) By signing and dating a piece of paper stating you revoke your health care directive;

2) By physically destroying the health care directive or having someone else destroy it in your presence and with your permission or instruction; or

3) By stating orally that you wish to revoke the health care directive.

Your revocation is effective as soon as you communicate it to your doctor or health care provider, and must be made a part of your medical record.

7. <u>CAN I BE REQUIRED TO SIGN A HEALTH CARE DIRECTIVE?</u>

No. No one may discriminate against you because you have or have not signed a health care directive.

8. <u>AFTER I HAVE SIGNED A HEALTH CARE DIRECTIVE, WHAT SHOULD I DO WITH IT?</u>

It is a good idea to talk about your health care directive with your doctor and other health care providers, and your family, since your doctor will probably consult them in the event you are unable to make your own health care decisions. Copies should be given to your agent, doctor, any other health care providers, and members of your family.

9. <u>WHAT IF I HAVE A HEALTH CARE DIRECTIVE, LIVING WILL, OR DURABLE POWER OF ATTORNEY WHICH WAS WRITTEN YEARS AGO?</u>

The statute governing health care directives in North Dakota was effective on August 1, 2005. If you signed a health care directive, living will, or durable power of attorney before August 1, 2005, it will remain in effect if it complied with the law in effect at the time you completed the directive. However, you may wish to execute a new health care directive since the new form is more detailed and will probably provide your family and health care provider with much more guidance on what kind of care you want in specific situations.

10. <u>CAN I INCLUDE DIRECTIONS AUTHORIZING THE WITHDRAWAL OR WITHHOLDING OF NUTRITION AND/OR HYDRATION IN MY HEALTH CARE DIRECTIVE?</u>

Yes. North Dakota law requires that nutrition and hydration or both must be withdrawn, withheld, or administered if the patient has previously declared IN WRITING the patient's desire that nutrition or hydration be withdrawn, withheld, or administered.

11. <u>WHAT DOES "HEALTH CARE DECISION" MEAN?</u>

It means to consent to, refuse to consent to, withdraw consent to, or request any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This includes:

1) Selection and discharge of health care providers and institutions;

2) Approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate;

3) Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care; and

4) Establishing where to live and receive care and support when those choices relate to health care needs.

12. <u>WHAT IF I HAVE QUESTIONS ABOUT ANY MEDICAL TREATMENT OR MEDICAL TERMS?</u>

You should talk to your doctor or some other medical professional that can tell you about various kinds of medical treatments, services, procedures, or life-sustaining care.

13. <u>WHAT IS AN AGENT?</u>

An agent is an adult that you give the authority to make health care decisions for you, as provided in your health care directive.

14. <u>WHO SHOULD I APPOINT AS MY AGENT?</u>

Your agent should be someone you know and trust, who knows how you feel about medical treatment, who understands your beliefs and values, and who is willing to carry out your wishes. Certain people <u>cannot</u> act as your agent though. These people are:

1) Your health care provider;

2) A non-relative who is employed by your health care

provider;

3) Your long-term care services provider; or

4) A non-relative who is employed by your long-term care services provider.

15. SHOULD I APPOINT AN ALTERNATE AGENT?

The appointment of an alternate agent is not required, but it is a good safeguard if something should happen to your original agent.

16. WHAT KIND OF HEALTH CARE DECISIONS CAN MY AGENT MAKE FOR ME?

Your agent will have the authority to make any and all health care decisions on your behalf that you could make yourself, with two exceptions:

1) Your agent cannot make a decision if you limit his or her authority to make such a decision on your behalf; or

2) Your agent cannot make a decision if the law prohibits him or her from making such a decision on your behalf.

17. WHAT KIND OF INSTRUCTIONS CAN I GIVE MY AGENT?

You may give very general instructions or be quite specific. You are not required to give your agent any instructions. If you do not give your agent any instructions, your agent will make decisions based upon your values as determined by your agent. If your agent is unable to determine what you would have decided, your agent must make decisions based upon what he or she believes to be best for you under the circumstances.

18. WHAT ARE MY AGENT'S RESPONSIBILITIES IN CARRYING OUT MY WISHES?

Your agent is required to follow your wishes as contained in your health care directive, if you have one, or as stated orally. If your wishes are unknown, your agent is required to make health care decisions for you based on what he or she feels is in your best interest.

19. <u>IS MY DOCTOR OR HEALTH CARE PROVIDER REQUIRED TO FOLLOW MY AGENT'S DECISIONS?</u>

Not in all circumstances. A health care provider may administer health care necessary to keep you alive, despite your agent's decision to withhold or withdraw health care. A health care provider may also withhold health care if he or she determines it to be contrary to reasonable medical standards, despite your agent's decision to provide health care. In these instances, the health care provider may not be subjected to civil or criminal liability or be considered to have engaged in unprofessional conduct if he or she took reasonable steps to:

1) Notify your agent of their unwillingness to comply;

2) Document the notification in your medical records; and

3) Arrange to transfer your care to another health care provider willing to comply with your agent's decision.

20. <u>WHEN DOES A HEALTH CARE DIRECTIVE BECOME EFFECTIVE?</u>

A health care directive is effective when all of the following occur:

1) You have executed a health care directive;

2) Your agent, if any, has accepted the position as agent in writing; and

3) Your doctor has certified, in writing, that you lack the capacity to make health care decisions. You lack capacity to make health care decisions when you do not have the ability to understand and appreciate the nature and consequences of a

health care decision, including the significant benefits and harms of proposed health care, or reasonable alternatives to that health care.

21. IF I AM A RESIDENT OF A LONG-TERM CARE FACILITY, ARE THERE ANY SPECIAL REQUIREMENTS?

Yes. If you are a resident of a nursing home or other long-term care facility at the time you sign a health care directive, it will not be effective unless either one of the following occurs:

1) One of the following persons signs a statement affirming that they have explained the nature and effect of the appointment of an agent to you:

    a) A member of the clergy;

    b) An attorney licensed to practice law in North Dakota;

    c) A person designated by the North Dakota Department of Human Services; or

    d) A person designated by the district court in the county where the facility is located.

2) You state in writing that you have read the explanation of the nature and effect of the appointment of an agent, or a person designated by the hospital or an attorney licensed to practice law in North Dakota signs a statement affirming that they have explained the nature and effect of the appointment to you.

22. IF I AM BEING ADMITTED TO OR AM A PATIENT IN A HOSPITAL, ARE THERE ANY SPECIAL REQUIREMENTS?

Yes. The appointment of an agent is not effective if, at the time of execution, you are being admitted to or are a patient in a hospital unless a person designated by the hospital or an attorney licensed to practice law in North Dakota signs a statement that they explained the nature and effect of the appointment to you, unless you acknowledge

in writing that you have read a written explanation of the nature and effect of the appointment.

23. CAN I STILL MAKE MY OWN HEALTH CARE DECISIONS AFTER I HAVE SIGNED A HEALTH CARE DIRECTIVE?

Yes. You will be able to make your own health care decisions as long as you are capable of doing so. Your agent's authority starts only when your doctor certifies in writing that you do not have the capacity to make health care decisions.

24. WHERE SHOULD I KEEP MY HEALTH CARE DIRECTIVE?

The original signed copy should be given to your agent or you should keep it where it is immediately available to your agent and your alternate agent, your doctor, and any other health care provider.

25. IS MY AGENT OR ALTERNATE AGENT LIABLE FOR MY HEALTH CARE COSTS?

No. The liability for the cost of your health care is the same as if you made the decision yourself.

26. CAN MY AGENT OR ALTERNATE AGENT WITHDRAW?

Yes. An agent or alternate agent may withdraw by giving you notice prior to the time you are determined to lack capacity to make health care decisions. After such time, your agent or alternate agent may withdraw by giving notice to your doctor.

27. WHEN DOES MY AGENT'S AUTHORITY END?

An agent's authority to make decisions on your behalf generally ends in five circumstances:

1) Upon your death;

2) When you regain capacity to make your own health care decisions;

3) If your agent withdraws;

4) If you revoke the agent's authority; or

5) If a court takes away your agent's authority to make health care decisions for you.

28. CAN I INSTRUCT MY AGENT TO WITHHOLD OR WITHDRAW NUTRITION AND/OR HYDRATION?

Yes. Nutrition or hydration or both must be withdrawn, withheld, or administered if you have previously declared your wishes in writing. However, there are limitations to this directive, as noted in question 19.

29. CAN I AUTHORIZE MY AGENT TO DONATE MY BODY ORGANS?

Yes. If you desire to donate your body organs after your death, you may specify your gift in your health care directive. You may make a gift of:

1) Any needed organs and tissues, and/or;

2) Specified organs or tissue.

INFORMED HEALTH CARE CONSENT LAW

This law can be found in Section 23-12-13 of the North Dakota Century Code.

The informed health care consent law establishes a priority list of persons who are authorized to provide consent for minors or persons who are incapacitated and, therefore, unable to make or communicate their own medical decisions. This law is particularly useful when a person does not have a health care directive.

The law applies to two groups of people: 1) minors, and 2) adults who are incapacitated. You are considered a minor if you are under age eighteen. You are considered incapacitated if you are unable to make or communicate responsible decisions regarding personal matters such as medical treatment.

This law requires that a person who is authorized to provide informed consent on your behalf must first determine that you would have consented to the proposed health care if you were able. If such a determination cannot be made, the authorized person may consent only after determining that the proposed health care is in your best interests.

QUESTIONS AND ANSWERS - INFORMED HEALTH CARE CONSENT LAW

This section includes a number of commonly asked questions and their answers regarding Informed Health Care Consent Law.

1. IF I HAVE A SIGNED HEALTH CARE DIRECTIVE, DOES THIS LAW APPLY?

   Possibly. If your health care directive is ambiguous or does not address a specific health care decision, this law will determine who may make such a decision for you.

2. IF I HAVE DESIGNATED AN AGENT IN MY HEALTH CARE DIRECTIVE, WILL THIS LAW APPLY?

   Possibly. There is an interaction between the law applicable to health care agents and the Informed Health Care Consent law. The interaction arises from the fact that the Informed Health Care Consent law provides that any person you give authority to act as your agent under a health care directive has highest priority to make health care decisions for you if you become incapacitated.

3. AT WHAT POINT WOULD THE LAW AUTHORIZE ANOTHER PERSON TO MAKE MY HEALTH CARE DECISIONS?

   A doctor must first determine that you are unable to make or communicate responsible health care decisions before anyone would be authorized to make health care decisions for you.

4. WHO IS AUTHORIZED BY LAW TO MAKE HEALTH CARE DECISIONS?

   The law authorizes the persons in the following categories, in the order listed, to make your health care decisions if you are either a minor or if your doctor determines that you are unable to make or communicate responsible decisions about your health care:

   1) Your agent under a health care directive, or durable power of

attorney, which gives the agent authority to make health care decisions for you, unless a court specifically authorizes a guardian to make medical decisions for you;

2) Your court-appointed guardian or custodian, if any;

3) Your spouse, if he or she has maintained significant contacts with you;

4) Any of your children who are at least eighteen years old and have maintained significant contacts with you;

5) Your parents, including a stepparent, who has maintained significant contacts with you;

6) Your adult brothers and sisters who have maintained significant contacts with you;

7) Your grandparents who have maintained significant contacts with you;

8) Your grandchildren who are at least eighteen years old and who have maintained significant contacts with you; or

9) A close relative or friend who is at least eighteen years of age and who has maintained significant contacts with you.

5. WHAT HAPPENS IF A PERSON IN A HIGHER CATEGORY REFUSES TO CONSENT TO THE PROPOSED HEALTH CARE?

No one in the lower category may provide consent to the proposed health care if someone in a higher category has refused to consent to the proposed health care.

6. <u>IS IT NECESSARY FOR EVERYONE IN A PARTICULAR CATEGORY TO CONSENT TO THE PROPOSED HEALTH CARE?</u>

No. A physician seeking informed consent for proposed health care must only receive the consent of one competent person in the highest-ranking category.

7. <u>ARE THERE ANY GUIDELINES WHICH MUST BE FOLLOWED BY THE PERSON AUTHORIZED TO GIVE CONSENT TO HEALTH CARE?</u>

Yes. Before giving consent, an authorized person must determine that you would have consented to such health care if you were able to do so. If the authorized person is unable to make this determination, he or she may only consent to the proposed health care if he or she feels the health care is in your best interest.

8. <u>ARE THERE ANY HEALTH CARE DECISIONS THAT THE LAW DOES NOT PERMIT ANYONE TO MAKE?</u>

Yes. Even individuals that are authorized to provide informed health care consent if you are a minor or incapacitated may not consent for you to receive any of the following treatments or procedures:

1) Sterilization;

2) Abortion;

3) Psychosurgery; or

4) Admission to a state mental health facility (state hospital) for a period of more than forty-five days, unless a court order is obtained.

9. WHAT IF I OR SOMEONE INTERESTED IN MY WELFARE OBJECTS TO MY DOCTOR'S CONCLUSION THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS?

If you or someone interested in your welfare objects to a doctor's decision that you are unable to make or communicate health care decisions, a court hearing must be held to determine whether you are able to make your own health care decisions.

HEALTH CARE DIRECTIVE

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 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 in 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: 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 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 I blank and go to Part II and/or 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.

When I am unable to make and communicate health care decisions 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 reasonably available, I trust and appoint _____________________ to be my health care agent instead.

Relationship of my alternate health care agent to me:______________

Telephone number of my alternate health care agent: _____________

Address of my alternate health care agent: ______________________

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 OR 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 has 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:

____
____
____

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).

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 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, at a minimum, Part II (B) if you wish to make a valid health care directive.

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

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

My goals for my health care:

____
____
____

My fears about my health care:

____
____
____

My spiritual or religious beliefs and traditions:

____

____

____

My beliefs about when life would be no longer worth living:

____

____

____

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).

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

____

____

____

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

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

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

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:

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

Who I would like to be my doctor:

Where I would like to live to receive health care:

Where I would like to die and other wishes I have about dying:

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

Any other things:
____
____
____

PART III: MAKING AN ANATOMICAL GIFT

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 the following (initial one statement):

[ ] Any needed organs and tissue.

[ ] Only the following organs and tissue:___________________________

PART IV: MAKING THE DOCUMENT LEGAL

PRIOR DESIGNATIONS REVOKED.
I revoke any prior health care directive.
DATE AND SIGNATURE OF PRINCIPAL
(YOU MUST DATE AND SIGN THIS HEALTH CARE DIRECTIVE)

I sign my name to this Health Care Directive Form on_____________
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 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:

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; or

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 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__.

Option 2: Two 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 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)

____

(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 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 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 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)

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 _________ , 20 _____ . ________________________
(Signature of Principal)

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 _________________________ (name of principal) who signed this document and 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 principal) who signed this document and who is a patient or is being admitted as a patient of ___________________ (name and city of hospital).

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)

23-06.5-18. Penalties.

1. A person who, without authorization of the principal, willfully alters or forges a health care directive or willfully conceals or destroys a revocation with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures which hastens the death of the principal is guilty of a class C felony.

2. A person who, without authorization of the principal, willfully alters, forges, conceals, or destroys a health care directive or willfully alters or forges a revocation of a health care directive is guilty of a class A misdemeanor.

3. The penalties provided in this section do not preclude application of any other penalties provided by law.