The Rest Of Your Life www.theroyl.com

*Advance Directive and Durable Power of Attorney*

# Advance Directive

State of New Hampshire

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

**Advance Directives Electronic Forms**

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

**Why do an Advance Directive?**

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.



An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

**Description**:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

**Security:**

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

**NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).**

# NEW HAMPSHIRE ADVANCE DIRECTIVE

*NOTE: This form has two sections: the Durable Power of Attorney for Health Care and the Living Will.*

You may complete both sections, or only one section.

## SECTION I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, EXAMPLE _____, (_____), hereby appoint _____
(Name) (Date of Birth) (Name of Health Care Agent)

of _____
(Health Care Agent's address and phone #)

*If you choose more than one agent, they will have authority in priority of the order their names are listed, unless you indicate another form of decision making.)* as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this directive or as prohibited by law. This Durable Power of Attorney for Health Care shall take effect in the event I lack the capacity to make my own health care decisions.

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 of Health Care Agent)



of _____
(Health Care Agent's address and phone #)

*(Please choose only one person. If you choose more than one alternate agent, they will have authority in priority of the order their names are listed.)*

Statement of Desires, Special Provisions, and Limitations about Health Care Decisions

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: 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. LIFE-SUSTAINING TREATMENT

1. If I am near death and lack the capacity to make health care decisions, I authorize my agent to direct that:

*(Initial beside your choice of (a) or (b).)*

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

2. Whether near death or not, if I become permanently unconscious I authorize my agent to direct that:

*(Initial beside your choice of (a) or (b).)*

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

## B. MEDICALLY ADMINISTERED NUTRITION AND HYDRATION

1. I realize that situations could arise in which the only way to allow me to die would be to not start or to discontinue medically administered nutrition and hydration. In carrying out any instructions I have given in this document, I authorize my agent to direct that:

*(Initial beside your choice of (a) or (b).)*

_____ (a) medically administered nutrition and hydration not be started, or if started, be discontinued.

-or-

_____ (b) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

If you fail to complete item B, your agent will not have the power to direct the withholding or withdrawal of medically administered nutrition and hydration.



## C. TREATMENT AGAINST OBJECTION

1. You may want your health care agent's decisions to be honored, even if you vocalize an objection to those decisions. In this context, please consider the following statement.

*(Initial beside your choice of (a) or (b).)*

_____ (a) Yes, even if I am incapacitated and I object to treatment, treatment **may** be given to me against my objection.

-or-

_____ (b) No, even if I am incapacitated, treatment **may not** be given to me against my objection.

## D. ADDITIONAL INSTRUCTIONS

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 are unacceptable to you for any other reason. You may leave this question blank if you desire.

_____

_____

_____

*(attach additional pages as necessary)*

EXAMPLE

_____, _____

(Print Name) (Date of Birth)

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

The original of this directive will be kept at _____ and the following persons and institutions will have copies:

_____

_____

_____

Signed this _____ day of _____, 20___.

Principal's signature: _____

*[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]*

***THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.***



We 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 affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness _____ Address _____

Witness _____ Address _____

**If using a Notary Public or Justice of the Peace:**

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Durable Power of Attorney for Health Care was acknowledged before me this _____ day of _____ , 20___, by _____ ("the Principal").

_____

Notary Public / Justice of the Peace

My commission expires: _____

EXAMPLE

_____, _____

(Print Name) (Date of Birth)

## SECTION II. LIVING WILL

Declaration made this _____ day of _____, 20___.

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness and I am certified to be near death or in a permanently unconscious condition by two physicians or a physician and an ARNP, and two physicians or a physician and an ARNP have determined that my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or that I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the natural ingestion of food or fluids by eating and drinking, or the performance of and medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue medically administered nutrition and hydration.

In carrying out any instruction I have given under this section, I authorize that:

*(Initial beside your choice of (a) or (b).)*



_____ (a) medically administered nutrition and hydration not be started, or if started, be discontinued.

-or-

_____ (b) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

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

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed this _____ day of _____, 20___.

Principal's signature: _____

*[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]*

EXAMPLE

_____, _____

(Print Name) (Date of Birth)

***THIS LIVING WILL DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.***

We declare that the principal appears to be of sound mind and free from duress at the time the Living Will is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness _____ Address _____

Witness _____ Address _____

**If using a Notary Public or Justice of the Peace:**

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Living Will was acknowledged before me
this _____ day of _____ , 20___, by _____ ("the Principal").

_____
Notary Public / Justice of the Peace

My commission expires: _____



_____, _____
(Print Name) (Date of Birth)

## Notice to Health Care Provider

**I have:**

____ a Durable Power of Attorney for Health Care

____ a Living Will

**The signed original document is located at:**

_____

_____

_____

**In case of emergency, contact:**

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone

## Advance Directive Card

_____
Name

_____
Address

_____
City, State, Zip

_____
Signature

**Please see reverse side for important information**

Fold Here


## Notice to Health Care Provider

**I have:**

____ a Durable Power of Attorney for Health Care

____ a Living Will

**The signed original document is located at:**

_____

_____

_____

**In case of emergency, contact:**

_____
Name

_____
Address

_____
City, State, Zip

_____
Phone

## Advance Directive Card

_____
Name

_____
Address

_____
City, State, Zip

_____
Signature

**Please see reverse side for important information**

Fold Here


*Cut these Advance Directive cards along the dotted lines, fold them in half and keep them in your wallet.*

Additional Pages: