

*Advance Directive And Durable Power Of Attorney*  
**Health Care Directive**

**State of North Dakota**

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).**

## HEALTH CARE DIRECTIVE

I EXAMPLE, 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:

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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:

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## 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:

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My fears about my health care:

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My spiritual or religious beliefs and traditions:

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

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My thoughts about how my medical condition might affect my family:

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**(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:

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

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

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

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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:

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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:

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Where I would like to live to receive health care:

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

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

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Any other things:

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**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.

EXAMPLE

\_\_\_\_\_  
(Signature of agent/date)

\_\_\_\_\_  
(Signature of alternate agent/date)

**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.



# A letter to my loved ones...

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Dear Loved Ones,

I want the best quality of life possible during my last days.  
Therefore, I hereby request as follows...

(a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.

(b) If my temperature is above normal, I want a cool moist cloth put on my head.

(c) I want my mouth and lips kept moist.

(d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.

(e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.

(f) I want my personal care such as nail clipping, hair combing, teeth brushing and shaving as long as they do not cause me pain.

*I hope my family and friends would consider that...*

(a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.

(b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.

(c) Please don't be afraid to hold my hand or hug me.

(d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me.

(e) Please maintain a cheerful atmosphere around me.

(f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.

(g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.

(h) If at all possible, allow me to die in my home.

(i) Please arrange for me to watch television or listen to my favorite sports events.

(j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.

(k) I want to have my favorite types of music played when possible.

(l) I want to have religious readings read to me when I am near death.

(m) I want to have my favorite poems read to me from time to time.

*I want you to know the following about my thoughts and concerns, if I am disabled and cannot convey these thoughts to you verbally...*

(1) I want you to know that I love you.

(2) I would like to be forgiven for the times I have hurt you.

(3) I forgive you for what you may have done to me in my life.

(4) I want you to know that I do not fear death itself.

(5) I want all of my family members to recommit their love for one another.

(6) Please remember me the way I was before I had a terminal illness.

(7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all.

(8) Don't be afraid to seek counseling, if you have trouble with my death.

*If friends want to know how I want to be remembered, tell them the following...*

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*The following person(s) know my funeral plans...*

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*At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...*

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*I also have the following requests...*

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**In Process**

**These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.**

*(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)*

Dated this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

Signature **EXAMPLE** \_\_\_\_\_

Print Name \_\_\_\_\_

4 of 4 Principal \_\_\_\_\_

Additional Pages:

In Process



Additional Pages:

In Process