

NORTH DAKOTA Advance Directive Planning for Important Health Care Decisions

Caring Connections

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Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care

Implement plans to ensure wishes are honored

Voice decisions to family, friends and health care providers

Engage in personal or community efforts to improve end-of-life care

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

INTRODUCTION TO YOUR NORTH DAKOTA ADVANCE DIRECTIVE

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **North Dakota Statutory Health Care Directive** lets you name someone to make decisions about your medical care — including decisions about life support — if you can no longer speak for yourself. The Health care Directive is especially useful because it appoints someone to speak for you any time you are incapacitated, not only at the end of life. It also lets you state your wishes about medical care in the event that you develop a terminal condition and can no longer make your own medical decisions.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

COMPLETING YOUR NORTH DAKOTA HEALTH CARE DIRECTIVE

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. Your agent may be a family member or a close friend whom you trust to make serious decisions. (An agent may also be called an “attorney-in-fact” or “proxy.”)

The person you appoint as your agent **cannot** be:

- your doctor or other treating health care provider,
- an employee of your treating health care provider who is not related to you,
- an operator of a long-term care facility, or
- an employee of an operator of a long-term care facility who is not related to you.

You can appoint a second and third person as alternate agents. The alternates will step in, by order of selection, if the first person you name as agent is unable, unwilling or unavailable to act for you.

Note: Your agent and alternate agent(s), if any, must sign Part IV the acceptance of appointment, to make the document effective.

How do I make my North Dakota Health Care Directive legal?

In order to make your Health Care Directive legally binding, you must sign your document, or direct someone to sign for you, in the presence of two witnesses or a notary, who must also sign the document.

These witnesses and the notary public **cannot**:

- be your spouse or be related to you by blood, marriage or adoption;
- stand to inherit from your estate upon your death;
- have any claim against your estate at the time you sign the document;
- be your doctor;
- be directly financially responsible for your medical care; or
- If two witnesses are signing your Health care Directive, at least one witness cannot be a health care provider giving direct care or an employee of the health care provider giving you direct care.

Note: The Notary Public may be an employee of a health care or long-term care provider providing direct care.

COMPLETING YOUR NORTH DAKOTA HEALTH CARE DIRECTIVE (CONTINUED)

Should I add personal instructions to my North Dakota Health Care Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your agent's power to act in your best interest. A statement such as "My agent knows my wishes concerning all forms of medical treatment" is sufficient.

Talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use Part II. Your agent must make health care decisions on your behalf according to your wishes and moral or religious beliefs as you have personally made known, either orally or in writing. If your agent does not know your wishes, he or she must act in your best interest.

What if I change my mind?

You may revoke your North Health Care Directive at any time by:

- notifying your agent or doctor, orally or in writing, of your intent to revoke your document, or
- executing another health care directive or durable power of attorney for health care.

NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE
- PAGE 1 OF 11

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____,
 (name)

 (address)

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

PART I: Name another person (called a 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 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).

**NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE
- PAGE 2 OF 11**

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 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.

ADD NAME OF HEALTH CARE AGENT, RELATIONSHIP, TELEPHONE NUMBER AND ADDRESS

ADD ALTERNATE AGENT'S NAME RELATIONSHIP, TELEPHONE NUMBER AND ADDRESS

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**NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE
- PAGE 3 OF 11**

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.

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 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:

LIST ANYTHING
YOU DON'T WANT
YOUR AGENT TO DO
FOR YOU

INITIAL IN FRONT
OF THE POWERS
YOU WANT YOUR
AGENT TO HAVE

LIST ANY
ADDITIONAL
INSTRUCTIONS
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:

My fears about my health care:

ADD PERSONAL
FEELINGS
(IF ANY)

**NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE
- PAGE 5 OF 11**

ADD PERSONAL
FEELINGS
(IF ANY)

My spiritual or religious beliefs and traditions:

My beliefs about when life would no longer be 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.)

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**NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE
- PAGE 6 OF 11**

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

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:

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**NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE
- PAGE 7 OF 11**

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

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 would want or do not want for my health care, if possible:

Who I would like to be my doctor: _____

Where I would like 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:

**NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE
- PAGE 8 OF 11**

ORGAN DONATION
(OPTIONAL)

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 Statutory Form Health Care Directive

on _____ at _____, _____.
(date) (city) (state)

(signature of principal)

(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.)

**NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE
- PAGE 9 OF 11**

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 witnesses:

- A person you designate as your agent or alternative agent;
- Your spouse;
- A person related to you by blood, marriage or adoption;
- A person entitled to inherit any part of your estate upon your death; or
- 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 the notary public)

My commission expires _____, 20_____.

OR

**NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE -
PAGE 10 OF 11**

Option 2: Two Witnesses

Witness One:

(1) In my presence on _____,
(date)

_____ acknowledged the
(name of declarant)

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) (date)

(address of witness one)

Witness Two:

(1) In my presence on _____,
(date)

_____ acknowledged the
(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) (date)

(address of witness two)

**NORTH DAKOTA STATUTORY FORM HEALTH CARE DIRECTIVE -
PAGE 11 OF 11**

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.

YOUR AGENT
AND ALTERNATE
AGENT(S) MUST
SIGN AND DATE
THE DOCUMENT

_____ (signature of agent)	_____ (date)
_____ (signature of first alternate agent)	_____ (date)
_____ (signature of second 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_____

YOU MUST SIGN
AND DATE THIS
DOCUMENT

Signature of Principal

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You Have Filled Out Your Advance Directive, Now What?

1. Your North Dakota Health Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your document after it has been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your North Dakota Health Care Directive.
6. Be aware that your North Dakota Health Care Directive will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**