**North Dakota Health Care Directive**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand this document allows me to do the following:

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.

HEALTH CARE INSTRUCTIONS

NOTE: Complete this part if you wish to give health care instructions. 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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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 the \_\_\_ day \_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (city, state).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

(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

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_

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)

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(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. (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)

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(Address)