

## **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

---

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING IT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except if you say otherwise in the directive, this directive gives the person you name as your health care agent the power to make any and all health care decisions for you when you lack the capacity to make health care decisions for yourself (in other words, you no longer have the ability to understand and appreciate generally the nature and consequences of a health care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care). "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your health care agent, therefore, will have the power to make a wide range of health care decisions for you. Your health care agent may consent (in other words, give permission), refuse to consent, or withdraw consent to medical treatment, and may make decisions about withdrawing or withholding life-sustaining treatment. Your health care agent cannot consent to or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy, unless the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this directive any treatment you do not want, or any treatment you want to be sure you receive. Your health care agent's power will begin when your doctor certifies that you lack the capacity to make health care decisions (in other words, that you are not able to make health care decisions). If for moral or religious reasons you do not want to be treated by a doctor or to be examined by a doctor to certify that you lack capacity, you must say so in the directive and you must name someone who can certify your lack of capacity. That person cannot be your health care agent or alternate health care agent or any person who is not eligible to be your health care agent. You may attach additional pages to the document if you need more space to complete your statement.

Under no conditions will your health care agent be able to direct the withholding of food and drink that you are able to eat and drink normally.

Your agent shall be directed by your written instructions in this document when making decisions on your behalf, and as further guided by your medical condition or prognosis. Unless you state otherwise in the directive, your agent will have the same power to make decisions about your health care as you would have made, if those decisions by your health care agent are made consistent with state law.

It is important that you discuss this directive with your doctor or other health care providers before you sign it, to make sure that you understand the nature and range of decisions which could be made for you by your health care agent. If you do not have a health care provider, you should talk with someone else who is knowledgeable about these issues and can answer your questions. Check with your community hospital or hospice for trained staff. You do not need a lawyer's assistance to complete this directive, but if there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

The person you choose as your health care agent should be someone you know and trust, and he or she must be at least 18 years old. If you choose your health or residential care provider (such as your



doctor, advanced practice registered nurse, or an employee of a hospital, nursing home, home health agency, or residential care home, other than a relative), that person will have to choose between acting as your health care agent or as your health or residential care provider, because the law does not allow a person to do both at the same time.

You should consider choosing an alternate health care agent, in case your health care agent is unwilling, unable, unavailable or not eligible to act as your health care agent. Any alternate health care agent you choose will then have the same authority to make health care decisions for you.

You should tell the person you choose that you want him or her to be your health care agent. You should talk about this directive with your health care agent and your doctor or advanced practice registered nurse and give each one a signed copy. You should write on the directive itself the people and institutions who will have signed copies. Your health care agent will not be liable for health care decisions made in good faith on your behalf.

**EVEN AFTER YOU HAVE SIGNED THIS DIRECTIVE, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AS LONG AS YOU ARE ABLE TO DO SO, AND TREATMENT CANNOT BE GIVEN TO YOU OR STOPPED OVER YOUR CLEAR OBJECTION.** You have the right to revoke the power given to your health care agent by telling him or her, or by telling your health care provider, orally or in writing, that you no longer want that person to be your health care agent.

**YOU HAVE THE RIGHT TO EXCLUDE OR STRIKE REFERENCES TO APRNS IN YOUR ADVANCE DIRECTIVE AND IF YOU DO SO, YOUR ADVANCE DIRECTIVE SHALL STILL BE VALID AND ENFORCEABLE.**

Once this directive is executed it cannot be changed or modified. If you want to make changes, you must make an entirely new directive.

**THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR JUSTICE OF THE PEACE OR TWO (2) OR MORE QUALIFIED WITNESSES, WHO MUST BOTH BE PRESENT WHEN YOU SIGN AND WHO WILL ACKNOWLEDGE YOUR SIGNATURE ON THE DOCUMENT. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:**

- The person you have designated as your health care agent
- Your spouse or heir at law
- Your attending physician or APRN, or person acting under the direction or control of the attending physician or APRN

**ONLY ONE OF THE TWO WITNESSES MAY BE YOUR HEALTH OR RESIDENTIAL CARE PROVIDER OR ONE OF YOUR PROVIDER'S EMPLOYEES.**



## APPOINTMENT OF AGENT

I, \_\_\_\_\_ of \_\_\_\_\_ [Address], hereby appoint \_\_\_\_\_ of \_\_\_\_\_ [Address], as my health care agent to make any and all health care decisions for me, except if I state otherwise in this document, or as prohibited by law. This Durable Power of Attorney for Health Care shall take effect in the event I become unable to make my own health care decisions.

In the event the person I choose as health care agent is unable, unwilling, unavailable or ineligible to act as my health care agent, I choose \_\_\_\_\_ of \_\_\_\_\_ [Address], as alternate health care agent.

## STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS ABOUT HEALTH CARE DECISIONS

### **LIFE-SUSTAINING TREATMENT**

Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions and antibiotics.

I wish to indicate my agreement with each of the following statements, and give my health care agent power to act in these specific circumstances.

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

Life-sustaining treatment continue to be given to me. \_\_\_\_\_ **Principal's initials**)

Life-sustaining treatment NOT be started, or if started, be discontinued. \_\_\_\_\_  
**(Principal's initials)**

2. Whether near death or not, if I become permanently unconscious and life-sustaining treatment has no reasonable hope of benefit, I authorize my agent to direct that: (Check and initial one)

Life-sustaining treatment continue to be given to me. \_\_\_\_\_ **Principal's initials**)

Life-sustaining treatment NOT be started, or if started, be discontinued. \_\_\_\_\_  
**(Principal's initials)**

3. 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 in this directive, I authorize my agent to direct that: (Check and initial one)

Even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me. \_\_\_\_\_ **(Principal's initials)**



Medically administered nutrition and hydration NOT be started, or if started, be discontinued.  
\_\_\_\_\_ (**Principal's** initials)

4. Do Not Resuscitate Order (Check and initial one)

I grant my agent the authority to request or agree to a do not resuscitate order (DNR). \_\_\_\_\_  
(**Principal's** initials)

I do NOT grant my agent the authority to request or agree to a do not resuscitate order (DNR).  
\_\_\_\_\_ (**Principal's** initials)

**ADDITIONAL INSTRUCTIONS**

I understand that in this paragraph I may include any specific desires or limitations I deem appropriate, such as my preferences concerning medically administered nutrition and hydration, when or what life-sustaining treatment I would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with my religious beliefs or are unacceptable to me for any other reason.

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

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 \_\_\_\_\_ [Address] and the following persons and institutions will have copies: \_\_\_\_\_

\_\_\_\_\_.

**In witness to this**, I sign my name this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
**Principal's** Signature

\_\_\_\_\_  
**Principal's** Name



THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE

**WITNESS SIGNATURES**

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

**First Witness**

---

**Witness 1** Signature

Date

---

**Witness 1** Full Name

---

**Witness 1** Address

---

City

State

Zip Code

**Second Witness**

---

**Witness 2** Signature

Date

---

**Witness 2** Full Name

---

**Witness 2** Address

---

City

State

Zip Code



**NOTARY ACKNOWLEDGEMENT OF PRINCIPAL**

State of New Hampshire                    )  
  )            **(Seal)**  
County of \_\_\_\_\_                    )

The foregoing durable power of attorney for health care was acknowledged before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by the undersigned, \_\_\_\_\_, who is personally known to me or satisfactorily proven to me to be the person whose name is subscribed to the within instrument.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_



**JUSTICE OF PEACE ACKNOWLEDGEMENT OF PRINCIPAL**

State of New Hampshire                    )  
  )            **(Seal)**  
County of \_\_\_\_\_                    )

The foregoing durable power of attorney for health care was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by the undersigned, \_\_\_\_\_, who is personally known to me or satisfactorily proven to me to be the person whose name is subscribed to the within instrument.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Justice of Peace

My Commission Expires: \_\_\_\_\_

