NORTH DAKOTA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CaringInfo, 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.

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

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

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

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. 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.

4. 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.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR NORTH DAKOTA ADVANCE DIRECTIVE

This packet contains a legal document, the **North Dakota Health Care Directive,** 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. You must fill out Part I, Part II, or both, for your document to be a valid advance directive. You may also fill out Part III, but it is optional. You must complete Part IV.

Part I is the **Power of Attorney for Health Care**, which lets you name someone to make decisions about your medical care—including decisions about life-sustaining treatments—if you can no longer speak for yourself. The Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your Power of Attorney for Health Care goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Part II, the **Health Care Instructions**, is your state's living will. It lets you state your wishes about medical care in the event that you can no longer make your own medical decisions.

Your Health Care Instructions go into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Part III is an **optional Organ Donation Form.**

Part IV contains the signature and witnessing provisions so that your document will be effective.

Your agent must sign **Part V accepting his or her appointment** in Part I in order for his or her power to become effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: This document will be legally binding only if the person completing it is a competent adult (at least 18 years old).

COMPLETING YOUR NORTH DAKOTA HEALTH CARE DIRECTIVE

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.

Neither of these witnesses nor the notary public may be:

- 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.

If your document is witnessed, at least one of your witnesses must not be a health care or long-term care provider providing you with direct care or an employee of a health care or long-term care provider providing you with direct care.

An agent appointed in Part I must also sign a copy of the advance directive at Part V, accepting his or her appointment in order for his or her power to become effective.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

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.

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 health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your North Dakota Health Care Directive at any time by notifying your agent or doctor, orally or in writing, of your intent to revoke your document, or by executing a new health care directive.

INTRODUCTION

PRINT YOUR NAME

PRINT YOUR ADDRESS

INTRODUCTION

I, _____,
(name)

_____
(address)

understand this document allows me to do ONE OR BOTH 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.

In addition, I may also do the following, but I understand it is optional:

PART III: Allows me to make an organ and tissue donation upon my death by signing a document of anatomical gift.

PART I

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. 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.

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

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:_____

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

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If the person I have named above is not reasonably available or is unable or unwilling to serve as my health care agent, 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:_____

INSTRUCTIONS FOR 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.

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:

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR AGENT'S POWERS

ATTACH ADDITIONAL PAGES, IF NEEDED

INITIAL (1) IF YOU WANT YOUR AGENT TO BE ABLE TO MAKE DECISIONS REGARDING ORGAN DONATION

INITIAL (2) IF YOU WANT YOUR AGENT TO BE ABLE TO MAKE DECISIONS REGARDING THE FINAL DISPOSITION OF YOUR REMAINS

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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 when I die, including organs, tissues, and eyes.

_____(2) To decide what will happen with my body when I die (burial, cremation, etc.).

If I want to say anything more about my health care agent's powers or limits on those powers, I can say it here:

PART II

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:

DESCRIBE YOUR BELIEFS AND VALUES ABOUT HEALTH CARE TO GUIDE HEALTH CARE DECISIONS ON YOUR BEHALF

My fears about my health care:

ATTACH ADDITIONAL PAGES IF NEEDED

DESCRIBE YOUR BELIEFS AND VALUES ABOUT HEALTH CARE TO GUIDE HEALTH CARE DECISIONS ON YOUR BEHALF

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.)

If I had a reasonable chance of recovery and were temporarily unable to make and communicate health care decisions for myself, I would want:

_____

_____

_____

_____

DESCRIBE YOUR CHOICES REGARDING HEALTH CARE UNDER THE CIRCUMSTANCES DESCRIBED

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:

_____

_____

_____

_____

ATTACH ADDITIONAL PAGES IF NEEDED

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

_____

_____

_____

_____

DESCRIBE YOUR CHOICES REGARDING PAIN MANAGEMENT

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:_____

DESCRIBE YOUR CHOICES REGARDING HEALTH CARE UNDER THE CIRCUMSTANCES DESCRIBED

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

_____

_____

_____

_____

_____

_____

ATTACH ADDITIONAL PAGES IF NEEDED

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

_____

_____

_____

_____

_____

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Any other things:

PART III

PART III: MAKING AN ANATOMICAL GIFT (Optional)

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent, guardian, or your family may have the authority to make a gift of all or part of your body under North Dakota law.

INITIAL ONLY ONE

[_____] I do not want to be an organ donor at the time of my death, and do not want my family, guardian, or agent to donate my organs on my behalf.

[_____] 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):

INITIAL ONLY ONE

[_____] Any needed organs and tissue.

[_____] Only the following organs and tissue:

_____

_____

_____

PRIOR HEALTH CARE DIRECTIVES

PRIOR DIRECTIVE REVOCATION NOTICE

By executing this document, I hereby revoke any prior health care directive.

PART IV

PART IV: EXECUTION

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.

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE WITNESSED, USE ALTERNATIVE NO. 1, BELOW (P. 12)

Neither of the witnesses nor the notary public may be:

- 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.

If your document is witnessed, at least one of your witnesses 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.

You and any agent appointed in Part I must also sign a copy of the advance directive in Part V to accept his or her role in order for his or her power to become effective.

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE NOTARIZED, USE ALTERNATIVE NO. 2, BELOW (P. 13)

If you decide to have your advance directive witnessed, use alternative No. 1, below.

If you decide to have your advance directive notarized, use alternative No. 2, below.

(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.**)**

DATE AND SIGN YOUR DOCUMENT HERE

YOUR WITNESSES MUST DATE AND PRINT YOUR NAME AND THEN SIGN AND DATE THE DOCUMENT AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST NOT BE YOUR HEALTH CARE PROVIDER OR EMPLOYEE OF YOUR HEALTH CARE PROVIDER

Alternative No. 1. Sign before witnesses

I sign my name to this Health Care Directive

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

_____
(signature of principal)

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.
I certify that the information in (1) and (2) 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) I am NOT a health care provider or an employee of a health care provider giving direct care to the declarant.
I certify that the information in (1) through (3) is true and correct.

_____ _____
(signature of witness two) (date)

_____
(address of witness two)

DATE AND SIGN YOUR DOCUMENT HERE

A NOTARY PUBLIC MUST FILL OUT THIS SECTION

Alternative No. 2. Sign before Notary Public

I sign my name to this Health Care Directive

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

_____
(signature of principal)

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_____.

PART V

PART V. 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 IN ORDER FOR THEIR POWER TO BE EFFECTIVE

_____ _____
(signature of agent) (date)

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

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

PRINCIPAL'S STATEMENT

I have read the materials explaining of the nature and effect of an appointment of a health care agent that are included in instructions to this health care directive.

Dated this _____ day of _____, 20_____

YOU MUST SIGN AND DATE THIS DOCUMENT HERE

_____
Signature of Principal

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care 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 it.

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 healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your North Dakota document.

7. Be aware that your North Dakota document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

GuideStar Exchange GOLD

OR donate online today: www.NationalHospiceFoundation.org/donate