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NEW HAMPSHIRE ADVANCE DIRECTIVE

NOTE: This form has two sections: the Durable Power of Attorney for Health Care and the Living Will. You may complete both sections, or only one section.

SECTION I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, (_____), hereby appoint _____
(Name) (Date of Birth) (Name of Health Care Agent)

of _____
(Health Care Agent's address and phone #)

(If you choose more than one agent, they will have authority in priority of the order their names are listed, unless you indicate another form of decision making.) as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this directive or as prohibited by law. This Durable Power of Attorney for Health Care shall take effect in the event I lack the capacity to make my own health care decisions.

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint _____
(Name of Health Care Agent)

of _____
(Health Care Agent's address and phone #)

Statement of Desires, Special Provisions, and Limitations about Health Care Decisions

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: medically administered nutrition and hydration, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish, you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

A. LIFE-SUSTAINING TREATMENT

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

(Initial beside your choice of (a) or (b).)

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

2. Whether near death or not, if I become permanently unconscious I authorize my agent to direct that:

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

B. EXPLAINING YOUR INSTRUCTIONS IN MORE DETAIL

(initial next to #'s 1 and 2, if you agree)

1. _____ I grant my agent authority to request or agree to a DNR order.

2. _____ Even if I am incapacitated and object to treatment, treatment may be given to me, or withheld, against my objection. This option is intended to grant your agent additional authority, if for example you have dementia, and you try to change the treatment being recommended by your agent and health provider.

You may include any specific desires or limitations you deem appropriate in the space below, such as your preferences concerning medically administered nutrition and hydration, when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or are unacceptable to you for any other reason. You may leave this question blank if you desire.

_____

_____

_____

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(attach additional pages as necessary)

_____, _____

(Print Name) (Date of Birth)

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 _____ and the following persons and institutions will have copies:

_____

_____

_____

Signed this _____ day of _____, 20___.

Principal's signature: _____

[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]

THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

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

Witness _____ Address _____

Witness _____ Address _____

If using a Notary Public or Justice of the Peace:

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Durable Power of Attorney for Health Care was acknowledged before me this _____ day of _____ , 20___, by _____ ("the Principal").

_____

Notary Public / Justice of the Peace

My commission expires: _____

_____, _____

(Print Name) (Date of Birth)

SECTION II. LIVING WILL

Declaration made this _____ day of _____, 20___.

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness and I am certified to be near death or in a permanently unconscious condition by two physicians or a physician and an APRN, and two physicians or a physician and an APRN have determined that my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or that I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the natural ingestion of food or fluids by eating and drinking, or the performance of any medical procedure deemed necessary to provide me with comfort care. 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.

(Initial below if it is your choice)

In carrying out any instruction I have given under this section, I authorize that even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me. _____

In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and health care providers as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

_____, _____

(Print Name) (Date of Birth)

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed this _____ day of _____, 20___.

Principal's signature: _____

[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]

THIS LIVING WILL DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time the Living Will is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness _____ Address _____

Witness _____ Address _____

If using a Notary Public or Justice of the Peace:

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Living Will was acknowledged before me
this _____ day of _____ , 20___, by _____ ("the Principal").

_____
Notary Public / Justice of the Peace

My commission expires: _____

_____, _____
(Print Name) (Date of Birth)