# *My Health Care Directive*

## My Health Care Agent

I, _____, trust and appoint _____ _____ as my health care agent. As my health care agent, this person can make health care decisions for me if I am unable to make and communicate health care decisions for myself. If my health care agent is not reasonably available, I trust and appoint _____ as my health care agent instead.

### My Wishes

*This is what I want my health care agent - or if I have no health care agent, whoever will make decisions regarding my care - to do if I am unable to make and communicate health care decisions for myself. Most of what I state here is general in nature since I cannot anticipate all the possible circumstances of a future illness. If I have not given specific instructions, then my agent must decide consistent with my wishes and beliefs.*

I believe that God created me for eternal life in union with Him. I understand that my life is a precious gift from God and that this truth should inform all decisions about my health care. I have a duty to preserve my life and to use it for God's glory. Suicide, euthanasia, and acts that intentionally and directly would cause my death by deed or omission, are never morally acceptable. However, I also know that death, being conquered by Christ, need not be resisted by any and every means and that I may refuse any medical treatment that is excessively burdensome or would only prolong my imminent death.

- Medical treatments may be foregone or withdrawn if they do not offer a reasonable hope of benefit to me or are excessively burdensome.
- There should be a presumption in favor of providing me with nutrition and hydration, including medically assisted nutrition and hydration, if they are of benefit to me.
- I have no moral objection to the use of medication or procedures necessary for my comfort even if they may indirectly and unintentionally shorten my life.
- If my death is imminent, I direct that there be forgone or withdrawn treatment that will only maintain a precarious and burdensome prolongation of my life, unless those responsible for my care judge at that time that there are special and significant reasons why I should continue to receive such treatment.
- If I fall terminally ill, I ask that I be told of this so that I might prepare myself for death, and I ask that efforts be made to attend to my spiritual needs in a manner consistent with my faith tradition.

Believing none of the following directives conflict with my faith or the directives listed above, I add the following directives: (You do not need to complete this section. If you do, you can use an extra sheet, if needed.)

_____

_____

_____

**Acceptance of Appointment by Health Care Agent**

I accept this appointment and agree to serve as a health care agent. I understand I have a duty to act in good faith, consistent with the desires expressed in this document, and that this document gives me authority to make health care decisions for the principal only when he or she is unable to make and communicate his or her own decisions.

I understand that the principal may revoke this appointment 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 competent, I must notify the principal's physician.

_____

(Signature of agent) (date)

_____

(Signature of alternate agent) (date)

**Health Care Agent Information**

Name:_____

Address:_____

Phones:_____

Relationship: _____

**Alternate Health Care Agent Information**

Name:_____

Address:_____

Phones:_____

Relationship: _____

**Making an Anatomical Gift (Optional)**

[ ] So long as it is consistent with my faith, I would like to be an organ and tissue donor at the time of my death.
[ ] I do not wish to be an organ donor.
[ ] I ask my health care agent to decide on organ donation, consistent with my beliefs.

Completion of this section is not needed to become an organ donor.

*Under North Dakota law execution of this health care directive automatically revokes any previous directives you may have.*

*If you have attached additional pages to this form, date and sign each of them at the same time you date and sign this form.*

*To be valid, this health care directive must be notarized or witnessed **when you sign**. If witnessed: At least one witness must not be a health care or long-term care provider providing you with direct care or an employee of that provider.*

***None of the following may be 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.*

**Your Signature** (The person making this health care directive) **[*This section must be completed.*]**

I sign this Health Care Directive on _____(date) at _____(city),

_____ (state).

_____ *(you sign here)*

**Option 1: To be Completed by a 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.

_____ My commission expires _____, 20___.
(Signature of Notary Public)

**Option 2: To be Completed by 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) (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) 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) (Address)