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Fifty-seventh
Legislative Assembly
of North Dakota

SENATE BILL NO. 2341
with House Amendments

SENATE BILL NO. 2341

Introduced by

Senators Lee, T. Mathern

Representatives Mahoney, Price, Svedjan

A BILL for an Act to amend and reenact sections 23-06.4-03, 23-06.5-05, and 23-06.5-16 and subsection 9 of section 23-06.5-17 of the North Dakota Century Code, relating to the form and execution of advance health care directives.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-06.4-03 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

23-06.4-03. Declaration relating to use of life-prolonging treatment.

1. An individual of sound mind and eighteen or more years of age may execute at any time a declaration governing the use, withholding, or withdrawal of life-prolonging treatment, nutrition, and hydration. The declaration must be signed by the declarant, or another at the declarant's direction, and ~~witnessed by two individuals who are not~~ contain verification of the declarant's signature or the signature of the person directed by the declarant to sign on behalf of the declarant, either by notary public or by two witnesses who are at least eighteen years of age. A person notarizing the declaration may be an employee of a health care or long-term care provider providing direct care to the declarant. At least one witness to the execution of the declaration must not be a health care provider providing direct care to the declarant or an employee of the health care provider providing direct care to the declarant on the date of execution. The notary public or any witness may not be:
   a. ~~Related~~ The declarant's spouse or related to the declarant by blood, marriage, or ~~marriage~~ adoption;

b. Entitled to any portion of the estate of the declarant under any will of the declarant or codicil to the will or deed, existing by operation of law or otherwise, at the time of the declaration;

c. Claimants against any portion of the estate of the declarant at the time of the execution of the declaration;

d. Directly financially responsible for the declarant's medical care; or

e. Attending physicians of the declarant.

2. ~~If the declarant is a resident of a long-term care facility, as defined in section 50-10.1-01, at the time the declaration is executed, one of the two witnesses to the declaration must be a recognized member of the clergy, an attorney licensed to practice in this state, or a person as may be designated by the department of human services or the district court for the county in which the facility is located.~~

~~3.~~ ~~A declaration must be substantially in the~~ The following statutory form~~, but the~~ is a preferred form, but not a required from, by which a person may execute a declaration. The declaration may include additional specific directives. Another form may be used if it complies with this chapter. The invalidity of any additional specific directives does not affect the validity of the declaration.

I declare on (month, day, year):

a. I have made the following decision concerning life-prolonging treatment (initial 1, 2, or 3):

(1) [ ] I direct that life-prolonging treatment be withheld or withdrawn and that I be permitted to die naturally if two physicians certify that:

(a) I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death;

(b) The application of life-prolonging treatment would serve only to artificially prolong the process of my dying; and

(c) I am not pregnant.

It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or

surgical treatment and that they accept the consequences of that refusal, which is death.

(2) [ ] I direct that life-prolonging treatment, which could extend my life, be used if two physicians certify that I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death. It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to direct that medical or surgical treatment be provided.

(3) [ ] I make no statement concerning life-prolonging treatment.

b. I have made the following decision concerning the administration of nutrition when my death is imminent (initial only one statement):

(1) [ ] I wish to receive nutrition.

(2) [ ] I wish to receive nutrition unless I cannot physically assimilate nutrition, nutrition would be physically harmful or would cause unreasonable physical pain, or nutrition would only prolong the process of my dying.

(3) [ ] I do not wish to receive nutrition.

(4) [ ] I make no statement concerning the administration of nutrition.

c. I have made the following decision concerning the administration of hydration when my death is imminent (initial only one statement):

(1) [ ] I wish to receive hydration.

(2) [ ] I wish to receive hydration unless I cannot physically assimilate hydration, hydration would be physically harmful or would cause unreasonable physical pain, or hydration would only prolong the process of my dying.

(3) [ ] I do not wish to receive hydration.

(4) [ ] I make no statement concerning the administration of hydration.

d. Concerning the administration of nutrition and hydration, I understand that if I make no statement about nutrition or hydration, my attending physician may withhold or withdraw nutrition or hydration if the physician determines that I

cannot physically assimilate nutrition or hydration or that nutrition or hydration would be physically harmful or would cause unreasonable physical pain.

e. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration is not effective during the course of my pregnancy.

f. I understand the importance of this declaration, I am voluntarily signing this declaration, I am at least eighteen years of age, and I am emotionally and mentally competent to make this declaration.

g. I understand that I may revoke this declaration at any time.

Signed _____

City, County, and State of Residence _____

~~The declarant is known to me and I believe the declarant to be of sound mind. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate upon the declarant's death. I am not the declarant's attending physician, a person who has a claim against any portion of the declarant's estate upon the declarant's death, or a person directly financially responsible for the declarant's medical care.~~

~~Witness _____~~

~~Witness _____~~

h. Option 1: 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 Notary Public)

My commission expires _____ , 20__.

i. 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 or long-term care provider or an employee of a health care or long-term 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 or long-term care provider or an employee of a health care or long-term 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)

~~4.~~ 3. A physician or other health care provider who is furnished a copy of the declaration shall make it a part of the declarant's medical record and, if unwilling to comply with the declaration, promptly so advise the declarant.

SECTION 2. AMENDMENT. Section 23-06.5-05 of the North Dakota Century Code is amended and reenacted as follows:

23-06.5-05. Execution and witnesses. The durable power of attorney for health care must be signed by the principal ~~in the presence of~~ and that signature must be verified by a notary public or at least two or more subscribing witnesses~~, neither of whom may~~ who are at least eighteen years of age. A person notarizing the document may be an employee of a health care or long-term care provider providing direct care to the principal. At least one witness to the execution of the document must not be a health care or long-term care provider providing direct care to the principal or an employee of a health care or long-term care provider providing direct care to the principal on the date of execution. The notary public or any witness may not be, at the time of execution, ~~be~~ the agent, ~~the principal's health or long-term care services provider or the provider's employee,~~ the principal's spouse or heir, a person related to the principal by blood, marriage, or adoption, a person entitled to any part of the estate of the principal upon the death of the principal under a will or deed in existence or by operation of law, ~~or~~ any other person who has, at the time of execution, any claims against the estate of the principal, a person directly financially responsible for the principal's medical care, or the attending physician of the principal. ~~The witnesses shall affirm that the principal appeared to be of sound mind and free from duress at the time the durable power of attorney for health care was signed and that the principal affirmed that the principal was aware of the nature of the documents and signed it freely and voluntarily.~~ If the principal is physically unable to sign, the durable power of attorney for health care may be signed by the principal's name being written by some other person in the principal's presence and at the principal's express direction.

SECTION 3. AMENDMENT. Section 23-06.5-16 of the North Dakota Century Code is amended and reenacted as follows:

23-06.5-16. Use of statutory form. The statutory form of durable power of attorney described in section 23-06.5-17 may be used and is the preferred form, but not a required form, by which a person may execute a durable power of attorney for health care pursuant to this chapter. It is known as "the statutory form of durable power of attorney for health care". Another form may be used if it complies with this chapter.

SECTION 4. AMENDMENT. Subsection 9 of section 23-06.5-17 of the 1999 Supplement to the North Dakota Century Code is amended and reenacted as follows:

9. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney For Health Care on_____ at _____

(date) (city)

_____

(state)

_____

(you sign here)

(THIS POWER OF ATTORNEY 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 POWER OF ATTORNEY.)

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. ~~A health care provider;~~
~~3. An employee of a health care provider;~~
~~4. The operator of a long-term care facility;~~
~~5. An employee of an operator of a long-term care facility;~~
~~6.~~ Your spouse;
~~7.~~ 3. A person related to you by blood, marriage, or adoption;
~~8.~~ 4. A person entitled to inherit any part of your estate upon your death; or
~~9.~~ 5. A person who has, at the time of executing this document, any claim against your estate.

~~I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider; an employee of a health care provider; the operator of a long-term care facility; an employee of an operator of a long-term care facility; the principal's spouse; a person related to the principal by blood or adoption; a person entitled to inherit any part of the principal's estate upon death; nor a person who has, at the time of executing this document, any claim against the principal's estate.~~

~~Signature: _____ Residence Address: _____~~

~~Print Name: _____ _____~~

~~Date: _____ _____~~

~~Signature: _____ Residence Address: _____~~

~~Print Name: _____ _____~~

~~Date: _____ _____~~

Option 1: 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 Notary Public)

My commission expires _____ , 20__.

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)

_____

(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)