

NORTH DAKOTA

STATUTORY FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen years of age and a resident of the state of North Dakota for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision.

This document gives your agent authority to request, consent to, refuse to consent to, or to withdraw consent for any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition if you are unable to do so yourself. This power is subject to any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent authorizes anything that is illegal; acts contrary to your known desires; or where your desires are not known, does anything that is clearly contrary to your best interest.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents, if any, or give each of them an executed copy of this document. You should give your doctor an executed copy of this document.

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.) If you wish to make a gift of any bodily organ you may do so pursuant to North Dakota Century Code chapter 23-06.2, the Uniform Anatomical Gift Act.

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

- a. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.
- b. Execute on my behalf any releases or other documents that may be required in order to obtain this information.
- c. Consent to the disclosure of this information.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", above.)

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all the following:

- a. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice".
- b. Any necessary waiver or release from liability required by a hospital or physician.

7. DURATION.

(Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)

This durable power of attorney for health care expires on

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

8. DESIGNATION OF ALTERNATE AGENTS.

(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved. Your agent may withdraw whether or not you are capable of designating another agent.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve

as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

a. First Alternate Agent:

(Insert name, address, and telephone number of the first alternate agent.)

b. Second Alternate Agent:

(Insert name, address, and telephone number of the second alternate agent.)

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 SIGNED BY TWO (2) 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.)

STATEMENT OF WITNESSES

This document must be witnessed by two (2) qualified adult witnesses.

None of the following may be used as a 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. A person related to you by blood or adoption;
8. A person entitled to inherit any part of your estate upon your death; or
9. 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 spouse 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: _____

10. ACCEPTANCE OF APPOINT 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 incapable. 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 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 incapable of making the principal's health care decisions, I must notify the principal's physician.

(Signature of agent/date)

(Signature of alternate agent/date)