~ North Dakota ~

Durable Power of Attorney For Health Care Christian Version

WARNING TO PERSON EXECUTING THIS DOCUMENT
NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make health care decisions for you. It revokes any prior power of attorney for health care that you may have made. If you wish to change your Durable Power of Attorney for Health Care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, your health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care agent, close family, or friends, if needed.

NORTH DAKOTA
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

Written in accordance with North Dakota Code § 23-06.5-17

Document made this _____ day of _____, _____.
Month Year

DESIGNATION OF HEALTH CARE AGENT

I, _____, _____
Print full legal name Address

_____, do hereby designate and appoint: _____
Print name of agent

_____, (____) _____
Address Phone

(Insert name, address, and telephone number of *one individual only* as your agent to make health care decisions for you. 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 an operator or a long-term care facility.)

as my health care agent to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a durable power of attorney for health care.

GENERAL STATEMENT OF AUTHORITY GRANTED

Subject to any limitations in this document, I do hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including my desires concerning obtaining, refusing, or withdrawing life–sustaining care, treatment, services, and procedures.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations on the lines provided under, "Statement of Desires, Special Provisions, and Limitations" below. You can indicate your desires by including a statement of your desires in the same paragraph.)

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided in this section. You should consider whether you want to include a statement of your desires concerning life–sustaining care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in this section. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space provided in this section. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.

In exercising the authority under this Durable Power of Attorney for Health Care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

1. Statement of desires concerning life–sustaining care, treatment, services, and procedures:

_____

_____

_____

2. Additional statement of desires, special provisions, and limitations regarding health care decisions:

_____

_____

_____

(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.

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 the following:

1. 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.

2. Choose my health care providers.

3. Choose where I live and receive care and support when those choices relate to my health care needs.

4. Review my medical records and have the same rights that I would have to give my medical records to other people.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations on the lines provided above.)

HIPAA RELEASE STATEMENT

I intend for my health care agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

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 of the following:

1. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

2. Any necessary waiver or release from liability required by hospital or physician.

DURATION

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

This durable power of attorney for health care expires on _____.
Date

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

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 on page 2, in the event that agent is unable or ineligible to act as your agent.

If the person designated as my agent on page 2 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:

First Alternate Agent:

Name: _____ Phone: (_____) _____

Address: _____

_____

Second Alternate Agent:

Name: _____ Phone: (_____) _____

Address: _____

_____

PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

ANATOMICAL GIFTS

Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____

_____

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

The principal and the witnesses or notary public must sign the document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

I sign my name to this Durable Power of Attorney for Health Care on _____
Date

at _____, _____.
City State

_____
Signature of Principal

THIS DURABLE POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS NOTARIZED OR SIGNED BY TWO (2) QUALIFIED ADULT 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 DURABLE POWER OF ATTORNEY FOR HEALTH CARE. 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. Your spouse;
3. A person related to you by blood 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.

STATEMENT OF WITNESSES

In my presence on _____, _____ acknowledged
Date Principal
the principal's signature on this document or acknowledged that the principal directed the person signing this document to sign on the principal's behalf. I am at least eighteen years of age.

If I am a health care provider or an employee of a health care provider giving direct care to the principal, I must initial this box: [_____].

I certify that the information above is true and correct.

Witness #1

Signature: _____ Print name: _____

Address: _____

In my presence on _____, _____ acknowledged
Date Principal
the principal's signature on this document or acknowledged that the principal directed the person signing this document to sign on the principal's behalf. I am at least eighteen years of age.

If I am a health care provider or an employee of a health care provider giving direct care to the principal, I must initial this box: [_____].

I certify that the information above is true and correct.

Witness #2

Signature: _____ Print name: _____

Address: _____

OR

NOTARY PUBLIC

In my presence on _____, _____ acknowledged
Date Principal
the principal's signature on this document or acknowledged that the principal directed the person signing this document to sign on the principal's behalf.

Signature of notary public: _____
(Seal, if any)

My commission expires: _____

ACCEPTANCE OF APPOINTMENT OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

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 durable power of attorney. I understand that the principal may revoke this durable 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 incapable of making the principal's health care decisions, I must notify the principal's physician.

Agent's signature: _____ Date: _____

First alternate agent's signature: _____ Date: _____

Second alternate agent's signature: _____ Date: _____

ADDENDUM TO THE STATE OF NORTH DAKOTA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my health care agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care agent may consent to the withholding or withdrawal of life–sustaining health care.

Revised 2018; Reviewed 2023

However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Durable Power of Attorney for Health Care Document, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withheld or withdrawn from me.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

PROVISION FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my health care agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES

My health care agent may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

A nursing home **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my health care agent may only admit me for short–term stays for recuperative care or respite care.

The principal and the witnesses or notary public must sign the document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

I sign my name to this Durable Power of Attorney for Health Care on _____
Date

at _____, _____.
City State

_____
Signature of Principal

THIS DURABLE POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS NOTARIZED OR SIGNED BY TWO (2) QUALIFIED ADULT 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 DURABLE POWER OF ATTORNEY FOR HEALTH CARE. 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. Your spouse;
3. A person related to you by blood 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.

STATEMENT OF WITNESSES

In my presence on _____, _____ acknowledged
Date Principal
the principal's signature on this document or acknowledged that the principal directed the person signing this document to sign on the principal's behalf. I am at least eighteen years of age.

If I am a health care provider or an employee of a health care provider giving direct care to the principal, I must initial this box: [_____].

I certify that the information above is true and correct.

Witness #1

Signature: _____ Print name: _____

Address: _____

In my presence on _____, _____ acknowledged
Date Principal
the principal's signature on this document or acknowledged that the principal directed the person signing this document to sign on the principal's behalf. I am at least eighteen years of age.

If I am a health care provider or an employee of a health care provider giving direct care to the principal, I must initial this box: [_____].

I certify that the information above is true and correct.

Witness #2

Signature: _____ Print name: _____

Address: _____

OR

NOTARY PUBLIC

In my presence on _____, _____ acknowledged
Date Principal
the principal's signature on this document or acknowledged that the principal directed the person signing this document to sign on the principal's behalf.

Signature of notary public: _____
(Seal, if any)

My commission expires: _____

STATEMENT OF HEALTH CARE AGENT

I understand that _____ has designated me to be his or her health care agent
Name of principal
if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Agent's signature: _____

Address: _____

STATEMENT OF ALTERNATE HEALTH CARE AGENTS

I understand that _____ has designated me to be his or her alternate
Name of principal
health care agent(s) if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

First Alternate agent's signature: _____

Second alternate agent's signature: _____

CLERGY
Optional

The principal has requested that the agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the agent to help meet the directives as described in this Durable Power of Attorney for Health Care document and attached Addendum.

Clergy's signature: _____ Phone: (_____) _____

Church address: _____

I have given copies of this Durable Power of Attorney for Health Care – Christian Version to:

_____

_____

_____

_____

_____

_____

_____