# Health Care Directive

(North Dakota Century Code §§ 23-06.5-01 to 23-06.5-19)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care agent in case of my incapacity.
2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.
3. **Regarding end-of-life matters:** [initial one of the two choices]

   (a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.

   (b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.
4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:

   _____

   _____

   _____

   _____
5. I give no one (including my agent) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.
6. Apart from the matters covered above, I appoint the person named herein as my agent to make health-care decisions for me. I give my agent full power and authority to consent to or to refuse treatment (including artificial nutrition and hydration) on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed agent is unavailable, unable, or unwilling to serve, I appoint an alternate agent herein to serve with the same power and authority.
7. **Regarding health-care decisions during pregnancy [if applicable]:** I direct that my health-care provider and my health-care agent fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my health-care agent has the authority to make health-care decisions for me even while I am pregnant.
8. THIS HEALTH CARE DIRECTIVE MUST BE SIGNED AND DATED BY THE PRINCIPAL, BY TWO WITNESSES, AND BY THE HEALTH-CARE AGENT AND ALTERNATE HEALTH-CARE AGENT.

   I sign my name to this Health Care Directive on the date indicated below.

_____ _____

(Signature of principal*) (Date)

_____

(Address)

STATEMENT OF WITNESSES: In my presence, the principal acknowledged his or her signature on this document or acknowledged that he or she directed another person to sign on his or her behalf. He or she appears to be of sound mind and free from duress, fraud, or undue influence. I am 18 years of age or older. **I am not (1) the principal's health-care agent or alternate agent,** (2) the principal's spouse or heir, (3) a person related to the principal by blood, marriage, or adoption, (4) a person entitled to inherit any part of the principal's

estate upon his or her death, (5) a person who has, at the time of executing this document, any claim against the principal's estate, (6) a person directly financially responsible for the principal's medical care, or (7) the principal's attending physician. Also, at least one of us is not the health-care provider, the long-term care provider, or the provider's employee that is providing direct care to the principal. I certify that the information contained in this Statement of Witnesses is true and correct.

(Signature of witness / Date) (Signature of witness / Date)

(Address) (Address)

## ACCEPTANCE OF APPOINTMENT 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 incapacitated. 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 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 not able to make health-care decisions, I must notify the principal's physician.

(Signature of health-care agent / Date) (Signature of alternate health-care agent / Date)

## HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

## ALTERNATE HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

*** Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your health-care agents). You should sign this document in the presence of two witnesses. You may appoint any adult to be your agent except (1) your treating health-care provider, (2) a nonrelative employee of your treating health-care provider, (3) your long-term care services provider, or (4) a nonrelative employee of your long-term care services provider. A "nonrelative" is a person who is not related to you by blood, marriage, or adoption.

**Health Care Directive**
(signed document inside)

**NO BLOOD**