INFORMATION CONCERNING

Durable Power of Attorney for Health Care

(New Hampshire Revised Statutes Annotated §§ 137-J:1 to 137-J:23)

DISCLOSURE STATEMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING IT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except if you say otherwise in the directive, this directive gives the person you name as your health-care agent the power to make any and all health-care decisions for you when you lack the capacity to make health-care decisions for yourself (in other words, you no longer have the ability to understand and appreciate generally the nature and consequences of a health-care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care). "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your health-care agent, therefore, will have the power to make a wide range of health-care decisions for you. Your health-care agent may consent (in other words, give permission), refuse to consent, or withdraw consent to medical treatment, and may make decisions about withdrawing or withholding life-sustaining treatment. Your health-care agent cannot consent to or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy, unless the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this directive any treatment you do not want, or any treatment you want to be sure you receive. Your health-care agent's power will begin when your doctor certifies that you lack the capacity to make health-care decisions (in other words, that you are not able to make health-care decisions). If for moral or religious reasons you do not want to be treated by a doctor or to be examined by a doctor to certify that you lack capacity, you must say so in the directive and you must name someone who can certify your lack of capacity. That person cannot be your health-care agent or alternate health-care agent or any person who is not eligible to be your health-care agent. You may attach additional pages to the document if you need more space to complete your statement.

Under no conditions will your health-care agent be able to direct the withholding of food and drink that you are able to eat and drink normally.

Your agent shall be directed by your written instructions in this document when making decisions on your behalf, and as further guided by your medical condition or prognosis. Unless you state otherwise in the directive, your agent will have the same power to make decisions about your health care as you would have made, if those decisions by your health-care agent are made consistent with state law.

It is important that you discuss this directive with your doctor or other health-care providers before you sign it, to make sure that you understand the nature and range of decisions which could be made for you by your health-care agent. If you do not have a health-care provider, you should talk with someone else who is knowledgeable about these issues and can answer your questions. Check with your community hospital or hospice for trained staff. You do not need a lawyer's assistance

to complete this directive, but if there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

The person you choose as your health-care agent should be someone you know and trust, and he or she must be at least 18 years old. If you choose your health- or residential-care provider (such as your doctor, advanced practice registered nurse, or an employee of a hospital, nursing home, home health agency, or residential-care home, other than a relative), that person will have to choose between acting as your health-care agent or as your health- or residential-care provider, because the law does not allow a person to do both at the same time.

You should consider choosing an alternate health-care agent, in case your health-care agent is unwilling, unable, unavailable or not eligible to act as your health-care agent. Any alternate health-care agent you choose will then have the same authority to make health-care decisions for you.

You should tell the person you choose that you want him or her to be your health-care agent. You should talk about this directive with your health-care agent and your doctor or advanced practice registered nurse (APRN) and give each one a signed copy. You should write on the directive itself the people and institutions who will have signed copies. Your health-care agent will not be liable for health-care decisions made in good faith on your behalf.

EVEN AFTER YOU HAVE SIGNED THIS DIRECTIVE, YOU HAVE THE RIGHT TO MAKE HEALTH-CARE DECISIONS FOR YOURSELF AS LONG AS YOU ARE ABLE TO DO SO, AND TREATMENT CANNOT BE GIVEN TO YOU OR STOPPED OVER YOUR CLEAR OBJECTION. You have the right to revoke the power given to your health-care agent by telling him or her, or by telling your health-care provider, orally or in writing, that you no longer want that person to be your health-care agent.

YOU HAVE THE RIGHT TO EXCLUDE OR STRIKE REFERENCES TO APRNs IN YOUR ADVANCE DIRECTIVE AND IF YOU DO SO, YOUR ADVANCE DIRECTIVE SHALL STILL BE VALID AND ENFORCEABLE.

Once this directive is executed it cannot be changed or modified. If you want to make changes, you must make an entirely new directive.

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR JUSTICE OF THE PEACE OR TWO (2) OR MORE QUALIFIED WITNESSES, WHO MUST BOTH BE PRESENT WHEN YOU SIGN AND WHO WILL ACKNOWLEDGE YOUR SIGNATURE ON THE DOCUMENT. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

- The person you have designated as your health-care agent;
- Your spouse or heir at law;
- Your attending physician or APRN, or person acting under the direction or control of the attending physician or APRN.

ONLY ONE OF THE TWO WITNESSES MAY BE YOUR HEALTH- OR RESIDENTIAL-CARE PROVIDER OR ONE OF YOUR PROVIDER'S EMPLOYEES.

Durable Power of Attorney for Health Care

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 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. **Regarding life-sustaining treatment:** Under New Hampshire law, life-sustaining treatment means "procedures without which a person would die, such as, but not limited to the following: mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics." Life-sustaining treatment includes "medically administered nutrition and hydration." If you want to give your health-care agent the authority to refuse blood transfusions and to act on your behalf on this issue, please initial the following statement:

   I specifically authorize my health-care agent and my alternate health-care agent to make decisions on my behalf about the provision, withholding, and withdrawal of life-sustaining treatment.

   [initial here, if you agree] _____

9. I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this directive. I have read and understand the information contained in the disclosure statement.

(Signature*) (Date)

(Address)

STATEMENT OF WITNESSES: We declare that the principal (the person who signed above) appears to be of sound mind and free from duress at the time the Durable Power of Attorney for Health Care is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily. The principal signed this document in our presence. We are both 18 years of age or older. **Neither of us is (1) the health-care agent or alternate agent appointed in this directive,** (2) the principal's spouse, (3) the principal's heir at law, (4) a person entitled to any part of the estate of the principal upon the death of the principal under a will, trust, or other testamentary instrument or deed in existence or by operation of law, (5) the principal's attending physician or advanced practice registered nurse, or (6) a person acting under the direction or control of the principal's attending physician or advanced practice registered nurse. At least one of us is not the principal's health-care or residential-care provider or the provider's employee.

(Signature of witness) (Signature of witness)

(Address) (Address)

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 for your health-care provider, your residential-care provider, or a nonrelative employee of your health-care provider or residential-care provider. A "nonrelative" is a person who is not related to you by blood, marriage, or adoption.

Durable Power of Attorney for Health Care
(signed document inside)

NO BLOOD