

NORTH CAROLINA Advance Directive Planning for Important Healthcare Decisions

Caring Connections

1731 King St., Suite 100, Alexandria, VA 22314

www.caringinfo.org

800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care

Implement plans to ensure wishes are honored

Voice decisions to family, friends and healthcare providers

Engage in personal or community efforts to improve end-of-life care

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Using These Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your North Carolina Advance Directive

This packet contains two legal documents that protect your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself.

1. The **North Carolina Healthcare Power of Attorney** is a form which gives the person you designate as your healthcare agent **broad powers** to make healthcare decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other healthcare decisions with your healthcare agent. Except to the extent that you express specific limitations or restrictions in this form, your healthcare agent may make any healthcare decision you could make yourself.

This form does not impose a duty on your healthcare agent to exercise granted powers, but when a power is exercised, your healthcare agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Healthcare Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

2. The **North Carolina Advance Directive for Natural Death (“Living Will”)** is a form you can use to give instructions for the future if you want your healthcare providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergy, and lawyers before you complete and sign this Living Will.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Instructions for Completing Your North Carolina Healthcare Power of Attorney

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent must be at least 18 years of age and should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (An agent may also be called an “attorney-in-fact” or “proxy.”)

You can appoint a second and third person as your alternate agent(s). The alternate will step in if the first person you name as agent is unable, unwilling or unavailable to act for you. Any person who is providing your healthcare for compensation cannot serve as your agent or alternate agent.

Extent of agent’s authority

You may grant the healthcare agent full power and authority to make healthcare decisions to the same extent that you could make those decisions for yourself if you had the capacity to make and communicate healthcare decisions, including the power to authorize withholding or discontinuing life-prolonging measures and the power to authorize the giving or withholding of mental health treatment. A healthcare power of attorney may also contain or incorporate by reference any lawful guidelines or directions relating to your healthcare as you deem appropriate.

A healthcare power of attorney may authorize the healthcare agent to exercise any and all rights you may have with respect to anatomical gifts, the authorization of any autopsy, and the disposition of your remains (cremation or burial); provided this authority is limited to incurring reasonable costs related to exercising these powers, and a healthcare power of attorney does not give the healthcare agent general authority over your property or financial affairs.

How do I make my North Carolina Healthcare Power of Attorney legal?

In order to make your Healthcare Power of Attorney legally binding, you must complete it and sign it in the presence of two witnesses and a notary public.

The witnesses must also sign the document to show that you signed it in their presence, that they believe you are of sound mind, and must state that they do not fall into any of the following categories of people who cannot be your witness.

Instructions for Completing Your North Carolina Healthcare Power of Attorney (continued)

These witnesses **cannot**:

- be related within the third degree to you or your spouse,
- know or have reason to believe that they would be entitled to any portion of your estate upon your death,
- have any claim against you or your estate at the time you sign the document
- be your doctor or mental health treatment provider or a licensed healthcare provider who is an employee of your doctor or of your mental health treatment provider,
- be an employee of a healthcare facility in which you are a patient, or an employee of a nursing home or any group-care home in which you are a resident

The notary public must notarize the document after you and the witnesses have signed it.

After the document has been signed and notarized, you should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advance Healthcare Directive Registry maintained by the North Carolina Secretary of State: <http://www.nclifelinks.org/ahcdr/>

When will my healthcare agent start making decisions on my behalf?

On page 11 (in the section of the form numbered 2) of the Healthcare Power of Attorney you may name the physician(s) who will determine when you lack the ability to make healthcare decisions for yourself. You may also name the physician or psychologist who will determine when you lack the ability to make health treatment decisions.

If you do not designate a physician or a psychologist or if the physician(s) or psychologist you designate is unavailable to make the determination, your attending physician will make the determination.

If you do not wish to designate a physician because of religious or moral beliefs, you may specify this in your healthcare power of attorney, and you may designate a competent adult of your choice to determine when you lack the ability to make healthcare decisions. The person you designate must not be your agent or involved in providing your healthcare for compensation. The person's determination that you lack competence to make medical decisions must be certified in writing and acknowledged before a notary public.

Instructions for Completing Your North Carolina Healthcare Power of Attorney (continued)

Should I add personal instructions to my North Carolina Healthcare Power of Attorney?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your agent's power to act in your best interest.

Talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific medical treatments or conditions, you should use your North Carolina Advance Directive for a Natural Death ("Living Will").

What if I change my mind?

You may revoke your Healthcare Power of Attorney at any time while you are still able to make and communicate healthcare decisions by:

- signing and dating a written revocation,
- executing a new Healthcare Power of Attorney, or
- any other action that communicates clearly and consistently to your healthcare agent or your healthcare provider your intent to revoke your agent's power.

Your revocation becomes effective once you notify your agent (s) and your doctor or psychologist. Your Healthcare Power of Attorney is automatically revoked if you appoint your spouse as your agent and your marriage ends (unless you have appointed an alternate agent).

If I have a Healthcare Power of Attorney executed in another state or country, will it be effective in North Carolina?

A healthcare power of attorney or similar document executed in a jurisdiction other than North Carolina shall be valid as a healthcare power of attorney in this State if it appears to have been executed in accordance with the applicable requirements of that jurisdiction **or** of this State.

Instructions for Completing Your North Carolina Advance Directive for a Natural Death (“Living Will”)

How do I make my Declaration legal?

In order to make your Living Will legally binding, you must complete it and sign it in the presence of two witnesses and a notary public.

The witnesses must also sign the document to show that you signed it in their presence, that they believe you are of sound mind, and must state that they do not fall into any of the following categories of people who cannot be your witness.

These witnesses **cannot**:

- be related within the third degree to you or your spouse,
- know or have reason to believe that they would be entitled to any portion of your estate upon your death,
- have any claim against you or your estate at the time you sign the document
- be your doctor or mental health treatment provider or of your mental health treatment provider,
- be an employee of a healthcare facility in which you are a patient, or an employee of a nursing home or any group-care home in which you are a resident

The notary public must notarize the document after you and the witnesses have signed it.

After the document has been signed and notarized, you should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advance Healthcare Directive Registry maintained by the North Carolina Secretary of State: <http://www.nclifelinks.org/ahcdr/>

What happens if I have a Healthcare Power of Attorney as well as a Living Will?

If you have appointed a healthcare agent by executing a healthcare power of attorney, the Living Will (in section numbered 6) gives you the option of directing **either** that your healthcare agent is authorized to give instructions which will override the provisions of the Living Will, **or** that the provisions of your Living Will will override any instructions given by your healthcare agent about prolonging your life.

What if I change my mind?

You may revoke your Living Will at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective once you, or somebody acting on your behalf, notifies your doctor.

**NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY
– PAGE 1 OF 9**

INSTRUCTIONS

PRINT YOUR NAME

PRINT YOUR
AGENT'S NAME,
ADDRESS AND
TELEPHONE
NUMBERS

NAME THE
PHYSICIAN (S) WHO
WILL DETERMINE
WHEN YOU CAN NO
LONGER MAKE
MEDICAL
DECISIONS

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1. Designation of Health Care Agent.

I, _____, being of sound mind,
(name)

hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

A. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

B. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

C. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
_____ Cellular Telephone: _____

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of appointment.

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. _____ (Physician)
2. _____ (Physician)

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY
- PAGE 2 OF 9

3. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

4. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 6 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

- A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.
- B. Employing or discharging my health care providers.
- C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.
- D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.
- E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."
- F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.
- G. Authorizing the withholding or withdrawal of life-prolonging measures.

NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY
- PAGE 3 OF 9

- H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorney's fees against anyone who does not comply with this health care power of attorney.

- I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

- J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. Special Provisions and Limitations.

(Notice: The authority granted in this document is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care treatment or service. If you wish to limit the scope of your health care agent's powers, you may do so in this section. If none of the following are initialed, there will be no special limitations on your agent's authority.)

**NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY
PAGE 4 OF 9**

INITIAL

_____ A. Limitations about Artificial Nutrition or Hydration: In exercising the authority to make health care decisions on my behalf, my health care agent shall NOT have the authority to withhold artificial nutrition (*Initial*) (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:

_____ B. shall NOT have the authority to withhold artificial hydration (*Initial*) (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:

INITIAL

NOTE: If you initial either block but do not insert any special provisions, your health care agent shall have NO AUTHORITY to withhold artificial nutrition or hydration.

_____ C. Limitations Concerning Health Care Decisions. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: your own definition of when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)

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NOTE: DO NOT initial unless you insert a limitation.

**NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY
PAGE 5 OF 9**

INITIAL

_____ D. Limitations Concerning Mental Health Decisions. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions: (Here you may include any specific provisions you deem appropriate such as: limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admission to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.)

NOTE: DO NOT initial unless you insert a limitation.

INITIAL

_____ E. Advance Instruction for Mental Health Treatment. (Notice: *(Initial)* This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event you lack capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment):

NOTE: DO NOT initial unless you insert a limitation.

**NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY
PAGE 6 OF 9**

INITIAL

_____ F. Autopsy and Disposition of Remains. In exercising the (Initial) authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial cremation):

NOTE: DO NOT initial unless you insert a limitation.

6. Organ Donation.

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

INITIAL

_____ Donate any needed organs or parts; or

INITIAL

_____ Donate only the following organs or parts:

NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.

INITIAL

_____ Donate my body for anatomical study if needed.

INITIAL

_____ In exercising the authority to make donations, my health care agent is subject to the following provisions and limitations: (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of the body or body parts.)

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NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.

7. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

8. Reliance of Third Parties on Health Care Agent.

- A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.
- B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

9. Miscellaneous Provisions.

- A. Revocation of Prior Powers of Attorney. I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY
PAGE 8 OF 9

- B. Jurisdiction, Severability, and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

- C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

- D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

- E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

PRINT DATE

This the _____ day of _____, 20 ____

_____ (SEAL)

NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY
PAGE 9 OF 9

PRINT NAME

I hereby state that the principal, _____,
being of sound mind, signed (or directed another to sign on the
principal's behalf) the foregoing health care power of attorney in my
presence, and that I am not related to the principal by blood or
marriage, and I would not be entitled to any portion of the estate of the
principal under any existing will or codicil of the principal or as an heir
under the Intestate Succession Act, if the principal died on this date
without a will. I also state that I am not the principal's attending
physician or mental health treatment provider, nor a licensed health
care provider or mental health treatment provider who is (1) an
employee of the principal's attending physician or mental health
treatment provider, (2) an employee of the health facility in which the
principal is a patient, or (3) an employee of a nursing home or any adult
care home where the principal resides. I further state that I do not have
any claim against the principal or the estate of the principal.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by

(type/print name of signer)

(type/print name of witness)

(type/print name of witness)

Date: _____

(Official Seal)

Signature of Notary Public

_____, Notary Public
Printed or typed name

My commission expires: _____

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Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
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INSTRUCTION

**NORTH CAROLINA ADVANCE DIRECTIVE FOR A NATURAL DEATH
("LIVING WILL") - PAGE 1 OF 5**

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

My Desire for a Natural Death

PRINT YOUR NAME

I, _____,
(name)

being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply ***IF*** my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY AND ALL OF THESE CHOICES.

_____ I have an incurable or irreversible condition that will result in my death within a relatively short period of time.

_____ I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.

_____ I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

2. These are My Directives about Prolonging My Life:

In those situations **I have initialed** in Section 1, I direct that my health care providers:

NOTE: INITIAL ONLY IN ONE PLACE.

_____ may withhold or withdraw life-prolonging measures.

_____ shall withhold or withdraw life-prolonging measures.

YOU MAY INITIAL ONE OR ALL OF THESE CHOICES

INITIAL ONLY ONE

**NORTH CAROLINA ADVANCE DIRECTIVE FOR A NATURAL DEATH
("LIVING WILL") - PAGE 2 OF 5**

3. Exceptions – "Artificial Nutrition or Hydration"

NOTE: INITIAL ONLY IF YOU WANT TO MAKE EXCEPTIONS TO YOUR INSTRUCTIONS IN SECTION 2.

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1:

_____ I *DO* want to receive BOTH artificial hydration AND artificial nutrition (for example, through tubes) in those situations.

NOTE: DO NOT INITIAL THIS BLOCK IF ONE OF THE BLOCKS BELOW IS INITIALED.

_____ I *DO* want to receive ONLY artificial hydration (for example, through tubes) in those situations.

NOTE: DO NOT INITIAL THE BLOCK ABOVE OR BELOW IF THIS BLOCK IS INITIALED.

_____ I *DO* want to receive ONLY artificial nutrition (for example, through tubes) in those situations.

NOTE: DO NOT INITIAL EITHER OF THE TWO BLOCKS ABOVE IF THIS BLOCK IS INITIALED.

4. I Wish to be Made as Comfortable as Possible

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

5. I Understand my Advance Directive

I am aware and understand that this document directs certain life-prolonging measures to be withheld or discontinued in accordance with my advance instructions.

INITIAL ONLY IF
YOU WANT TO
MAKE EXCEPTION
TO YOUR
INSTRUCTIONS IN
SECTION 2

**NORTH CAROLINA ADVANCE DIRECTIVE FOR A NATURAL DEATH
("LIVING WILL") - PAGE 3 OF 5**

6. If I have an Available Health Care Agent

If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that:

INITIAL

_____ Follow Advance Directive: This Advance Directive will **override** instructions my health care agent gives about prolonging my life.

INITIAL

_____ Follow Health Care Agent: My health care agent has authority to **override** this Advance Directive.

NOTE: DO NOT INITIAL BOTH BLOCKS. IF YOU DO NOT INITIAL EITHER BOX, THEN YOUR HEALTH CARE PROVIDERS WILL FOLLOW THIS ADVANCE DIRECTIVE AND IGNORE THE INSTRUCTIONS OF YOUR HEALTH CARE AGENT ABOUT PROLONGING YOUR LIFE.

7. My Health Care Providers May Rely on this Directive

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

8. I Want this Directive to be Effective Anywhere

I intend that this Advance Directive be followed by any health care provider in any place.

9. I have the Right to Revoke this Advance Directive

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

**NORTH CAROLINA ADVANCE DIRECTIVE FOR A NATURAL DEATH
("LIVING WILL") - PAGE 4 OF 5**

PRINT THE DATE,
MONTH AND YEAR

This the _____ day of _____, _____.

PRINT YOUR NAME

Print Name

I hereby state that the declarant, _____, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed health care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by

(type/print name of declarant)

(type/print name of witness)

(type/print name of witness)

**NORTH CAROLINA ADVANCE DIRECTIVE FOR A NATURAL DEATH
("LIVING WILL") - PAGE 5 OF 5**

PRINT THE DATE

Date: _____
(Official Seal) Signature of Notary Public

PRINT YOUR NAME

_____, Notary Public
Printed or typed name

My commission expires: _____

*Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898*

You Have Filled Out Your Advance Directive, Now What?

1. Your North Carolina Healthcare Power of Attorney and North Carolina Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and alternates, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your North Carolina documents.
6. Be aware that your North Carolina documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**