NEW HAMPSHIRE ADVANCE DIRECTIVE

NOTE: This form has two sections: the Durable Power of Attorney for Health Care and the Living Will. You may complete both sections, or only one section.

SECTION I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____ (_____), hereby appoint _____
(Name) (Date of Birth) (Name of Health Care Agent)

of _____
(Health Care Agent's address and phone #)

(If you choose more than one agent, they will have authority in priority of the order their names are listed, unless you indicate another form of decision making.) as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this directive or as prohibited by law. This Durable Power of Attorney for Health Care shall take effect in the event I lack the capacity to make my own health care decisions.

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint _____
(Name of Health Care Agent)

of _____
(Health Care Agent's address and phone #)

Statement of Desires, Special Provisions, and Limitations about Health Care Decisions

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: medically administered nutrition and hydration, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish, you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

A. LIFE-SUSTAINING TREATMENT

1. If I am near death and lack the capacity to make health care decisions, I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

2. Whether near death or not, if I become permanently unconscious I authorize my agent to direct that:

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

B. EXPLAINING YOUR INSTRUCTIONS IN MORE DETAIL

(initial next to #'s 1 and 2, if you agree)

1. _____ I grant my agent authority to request or agree to a DNR order.

2. _____ Even if I am incapacitated and object to treatment, treatment may be given to me, or withheld, against my objection. This option is intended to grant your agent additional authority, if for example you have dementia, and you try to change the treatment being recommended by your agent and health provider.

You may include any specific desires or limitations you deem appropriate in the space below, such as your preferences concerning medically administered nutrition and hydration, when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or are unacceptable to you for any other reason. You may leave this question blank if you desire.

(attach additional pages as necessary)

_____, _____

(Print Name) (Date of Birth)

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.

The original of this directive will be kept at _____ and the following persons and institutions will have copies:

_____

_____

_____

Signed this _____ day of _____, 20___.

Principal's signature: _____

[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]

THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal 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.

Witness _____ Address _____

Witness _____ Address _____

If using a Notary Public or Justice of the Peace:

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Durable Power of Attorney for Health Care was acknowledged before me this _____ day of _____ , 20___, by _____ ("the Principal").

_____

Notary Public / Justice of the Peace

My commission expires: _____

_____, _____

(Print Name) (Date of Birth)