New Hampshire Advance Directive Form

Name (Principal's Name): _____
DOB: _____
Address: _____

I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

The durable power of attorney for healthcare form names your agent(s) and, if you wish, sets limits on what your agent can decide.

I choose the following person(s) as agent(s) if I have lost capacity to make health care decisions (cannot make health care decisions for myself).

(If you choose more than one person, they will become your agent in the order written, unless you indicate otherwise.)

A. Choosing Your Agent:

Agent: I appoint _____, of _____, and whose phone number is _____ to be my agent to make health care decisions for me.

Alternate Agent: If the person above is not able, willing, or available, I appoint _____, of _____, and whose phone number is _____ to be my alternate agent.

If no one listed above can make decisions for you, a surrogate will be assigned in the order written in law (spouse, adult child, parent, sibling, etc.), and will have the same powers as an agent. If there is no surrogate, a court appointed guardian may be assigned.

B. Limiting Your Agent's Authority or Providing Additional Instructions

When you can no longer make your own health care decisions, your agent will be able to make decisions for you. Please review the Disclosure Statement that is attached to this Advance Directive for examples of how you may want to advise your agent. You may write in limits or additional instructions below or attach additional pages.

_____

_____

_____

_____

I have attached _____ additional pages titled *Additional Wishes for my Durable Power of Attorney for Health Care* to express my wishes.

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II. LIVING WILL

If you would like to provide written guidance to your agent, surrogate, and/or medical practitioners in making decisions about life sustaining medical treatment if you cannot make your own decisions, you may complete the options below.

CHOOSE ITEM A OR B. Initial your choice:

If I suffer from an advanced life-limiting, incurable and progressive condition:

_____ A. I wish to have all attempts at life-sustaining treatment (within the limits of generally accepted health care standards) to try to extend my life as long as possible, no matter what burdens, costs or complications may occur.

OR

_____ B. I wish to receive only those forms of life-sustaining treatment that I would not consider to be excessively burdensome AND that have a reasonable hope of benefit for me. I do NOT wish to have any life-sustaining treatment attempted that I would consider to be excessively burdensome or that would not have a reasonable hope of benefit for me. This would include the following statements EXCEPT any I have crossed out and initialed:

1. I do not wish to have life-sustaining treatment attempted if I am actively dying (medical treatment will only prolong my dying).

2. I do not wish to have life-sustaining treatment attempted if I become permanently unconscious with no reasonable hope of recovery.

3. I do not wish to have life-sustaining treatment attempted if I suffer from an advanced life-limiting, incurable and progressive condition and if the likely risks and burdens of treatment would outweigh the expected benefits. *I will describe additional situations I would find excessively burdensome below, if I suffer from an advanced life-limiting, incurable and progressive condition.*

(I have attached ____ additional pages titled "Living Will Burdens").

_____

_____

In these situations, I wish for comfort care only. I understand that stopping or starting treatments to achieve my comfort, including stopping medically-administered nutrition and hydration, may be a way to allow me to die when the treatments would be excessively burdensome for me.

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III. SIGNATURE

I have received, reviewed, and understood the disclosure statement, and I have completed the Durable Power of Attorney for Health Care and/or Living Will consistent with my wishes. I have attached _____ pages to better express my wishes.

Signed this _____ day of _____, 20_____

Principal's Signature: _____

Principal's Name: _____
DOB: _____
Address: _____

(If you are physically unable to sign, this Advance Directive may be signed by someone else writing your name in your physical presence at your direction.)

THIS ADVANCE 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 this Advance Directive is signed and that the principal affirms that the principal is aware of the nature of the directive and is signing it freely and voluntarily.

Witness: _____ Address (city/state): _____

Witness: _____ Address (city/state): _____

IF USING A NOTARY PUBLIC OR JUSTICE OF THE PEACE:

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Advance Directive was acknowledged before me this _____ day of _____, 20_____, by _____ (the "Principal").

Notary Public/Justice of the Peace:_____

My commission expires: _____