



LIVING WILLS AND HEALTH CARE POWERS OF ATTORNEY

To many people, the fear of a lingering death is worse than the fear of dying. Yet often near the end of one's life, one is unable to make decisions or express desires concerning medical care to loved ones or medical personnel. A living will and a health care power of attorney are legal documents that will permit you to make certain choices regarding your future health care and will allow you to appoint another individual to make those decisions for you in the event that you are unable to make them for yourself.

What is a Living Will?

A living will is a document which allows you to retain control over whether your life will be prolonged by certain medical procedures if you are diagnosed as being terminally and incurably ill or in a persistent vegetative state (i.e., a sustained complete loss of self-awareness). In North Carolina, this is called "A Declaration of A Desire for a Natural Death." A living will allows you to authorize the withholding of extraordinary means of keeping you alive (for example, respirator care) and may authorize the withholding or discontinuance of artificial nutrition or hydration. You may make different choices as to the level of care to be withheld or discontinued depending upon whether your medical condition is terminal and incurable or you are in a persistent vegetative state.

What is a Health Care Power of Attorney?

A health care power of attorney is a document by which you may appoint another person who may consent to or refuse medical care, including mental health treatment, on your behalf if a physician or eligible psychologist determines that you are unable to make or communicate these decisions yourself. You may authorize the designated person (the "health care agent") to consent to the withholding or withdrawal of life-sustaining procedures in the event you are determined to be: (1) terminally ill, (2) permanently in a coma, (3) suffering from severe dementia, or (4) in a persistent vegetative state. Life-sustaining procedures are those which only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and any other medical treatment (other than care to provide comfort or alleviate pain). In addition to making decisions in "life and death" situations, your health care agent also may be authorized to make more routine medical decisions for you (for example, to consent to X-rays or surgery). You may include instructions to your health care agent to refuse any specific types of treatment that are unacceptable to you

for religious or other reasons. In the event of death, you may authorize your health care agent to donate your organs and authorize an autopsy. A health care power of attorney will not be effective if a court appoints a guardian to act on your behalf. However, you may indicate in the document your choice of a guardian in the event guardianship proceedings are commenced.

How Should a Living Will or Health Care Power of Attorney Be Made?

The forms used to make a living will or health care power of attorney follow this information. A health care power of attorney may be a separate document or may be included in a broader durable power of attorney document addressing other matters than consent for and refusal of medical care. A living will and a health care power of attorney must be witnessed and signed in accordance with North Carolina law and must be certified by a notary public. At least two witnesses are required for a living will and a health care power of attorney. Witnesses cannot be related to the person signing the documents or be potential heirs to the person's estate. Nor may an attending physician or employees of the physician or health care institution be witnesses for these documents; however, such employees may notarize the document. Because they are not employees of the physician or health care institution, volunteers may witness the execution of a living will or health care power of attorney. Witnesses can have no claim against the individual. You should carefully consider the implications of executing these documents, both as to the course of your future medical care and as to the effect of your decisions on your loved ones. It is strongly suggested that you consult with family members prior to executing these documents.

Can I Have Both a Living Will and a Health Care Power of Attorney?

Yes. You may have a living will indicating your choice of health care in the event you are unable to make those decisions in the future, and you also may have a health care power of attorney designating an individual to act on your behalf. In fact, you may even have a living will and a health care power of attorney in the same document. By addressing these issues in a single document, the risk of any inconsistency in separate documents can be avoided. However, if you are in a condition not covered by your living will, then the health care power of attorney will govern. In the event of a conflict between the wishes expressed in your living will and a decision made by your health care agent, your living will governs.

Can I Change My Mind Once I Sign a Living Will or Appoint a Health Care Agent?

Yes. You may revoke a living will at any time that you are able to communicate health care decisions. You may revoke a health care power of attorney if you are also capable of making health care decisions. You may do so by executing and acknowledging an instrument of revocation, executing a subsequent living will or health care power of attorney, or by any other manner by which you are able to communicate your intent to revoke. The revocation will become effective only upon communication to the attending physician and to each health care agent named if a health care power of attorney is to be revoked. These documents should be reviewed periodically, especially in the event of divorce or death or disability of a named agent, to ensure that they continue to reflect your desires about health care decisions.

If I Do Not Have a Living Will or Health Care Power of Attorney, Who Will Make These Decisions for Me?

If an individual does not have a living will or health care power of attorney, the decisions will be made by the patient's spouse or next of kin, unless a court has appointed a guardian. Under the provisions of North Carolina statutes, such individuals may consent to withdrawal of medical care for patients who are terminally and incurably ill or in a persistent vegetative state after confirmation of this condition by physicians.

Where Should I Keep My Living Will or Health Care Power of Attorney Document?

It is suggested that you give a copy of these documents to your family physician, attorney and family members. A signed copy of a health care power of attorney document also should be given to your health care agent and any alternate named in your health care power of attorney. A safety deposit box or locked safe is not recommended for storage of these documents.

NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY

NOTICE: This document gives the person you designate your health care agent broad powers to make health care decisions for you, including the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive. This power exists only as to those health care decisions for which you are unable to give informed consent.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised; your health care agent will have to use due care to act in your best interest and in accordance with this document. Because the powers granted by this document are broad and sweeping, you should discuss your wishes concerning life-sustaining procedures with your health care agent.

Use of this form in the creation of a health care power of attorney is lawful and is authorized pursuant to North Carolina law. However, use of this form is an optional and nonexclusive method for creating a health care power of attorney and North Carolina law does not bar the use of any other or different form of power of attorney for health care that meets the statutory requirements.

1. Designation of Health Care Agent

I, _____, being of sound mind, hereby appoint

Name: _____

Home Address: _____

Home Telephone No.: _____ Work Telephone No.: _____

as my health care attorney-in-fact (herein referred to as my "health care agent") 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.

If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: **(Optional)**

Name: _____

Home Address: _____

Home Telephone No.: _____ Work Telephone No.: _____

Name: _____

Home Address: _____

Home Telephone No.: _____ Work Telephone No.: _____

Each successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent.

2. Effectiveness of Appointment

(NOTICE: This health care power of attorney may be revoked by you at any time in any manner by which you are able to communicate your intent to revoke to your health care agent and your attending physician.)

Absent revocation, the authority granted in this document shall become effective when and if the physician or physicians designated below determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my death. The following physician or physicians shall make this determination.

(You may include here a designation of your choice, including your attending physician, or any other physician. You may also name two or more physicians, if desired, both of whom must make this determination before the authority granted to the health care agent becomes effective.)

3. General Statement of Authority Granted

Except as indicated in section 4 below, I hereby grant to my health care agent named above full power and authority to make health care decisions on my behalf, including, but not limited to, the following:

- A. To request, review, and receive 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. To employ or discharge my health care providers;
- C. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution;
- D. To give consent for, to withdraw consent for, or to withhold 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, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain.
- E. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. Life-sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain.

I DESIRE THAT MY LIFE NOT BE PROLONGED BY LIFE-SUSTAINING PROCEDURES IF I AM TERMINALLY ILL, PERMANENTLY IN A COMA, SUFFER SEVERE DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE STATE.

- F. To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains.
- G. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

4. Special Provisions And Limitations

(Notice: The above grant of power 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. If you wish to limit the scope of your health care agent's powers, you may do so in this section.)

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 and limitations. (Here you may include any specific limitations you deem appropriate such as: your own definition of when life-sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or unacceptable to you for any other reason.)

5. Guardianship Provision

If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person to serve without bond or security.

6. 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 legal heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent.
- 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 act 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.

7. Miscellaneous Provisions

- A. I revoke any prior health care power of attorney.
- B. My health care agent shall be entitled to sign, execute, deliver and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs.
- C. 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, and assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence.
- D. No act or omission of my health care agent, or of any other person, 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 lack of professional competence. Any person, institution, or facility against which criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

8. Signature of Principal

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.

Signature of Principal

Date

9. Signatures of Witnesses

I hereby state that the Principal _____, being of sound mind, signed 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, nor an employee of the attending physician, nor an employee of the health facility in which the principal is a patient, nor an employee of a nursing home or any group-care home where the principal resides. I further state that I do not have any claim against the principal.

Witness

Date

Witness

Date

10. Notary

STATE OF NORTH CAROLINA

COUNTY OF _____

CERTIFICATE

I, _____, a Notary Public for _____ County, North Carolina, hereby certify that _____, appeared before me and swore to me and to the witnesses in my presence that this instrument is a Health Care Power of Attorney, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____ and _____, witnesses appeared before me and swore that they witnessed _____ sign the attached Health Care Power of Attorney, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his/her estate upon his/her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him/her, nor an employee of an attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of a nursing home or any group-care home in which he/she resided, and (iv) they did not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the _____ day of _____, 20 _____

Notary Public _____

My Commission Expires: _____

(A copy of this form should be given to your health care agent and any alternate named in this power of attorney, and to your physician and family members.)

NORTH CAROLINA
COUNTY OF _____

DECLARATION OF A DESIRE FOR A NATURAL DEATH

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by extraordinary means or by artificial nutrition or hydration if my condition is determined to be terminal and incurable or if I am diagnosed as being in a persistent vegetative state. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means or artificial nutrition or hydration, in accordance with my specifications set forth below:

(Initial any of the following, as desired):

____ If my condition is determined to be terminal and incurable, I authorize the following:

____ My physician may withhold or discontinue extraordinary means only.

____ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

____ If my physician determines that I am in a persistent vegetative state, I authorize the following:

____ My physician may withhold or discontinue extraordinary means only.

____ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

This the _____ day of _____

Signature: _____

I hereby state that the declarant, _____, being of sound mind signed the above declaration in my presence and that I am not related to the declarant by blood or marriage and that I do not know or have a reasonable expectation that I would 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 or an employee of the declarant's attending physician, or an employee of a health facility in which the declarant is a patient or an employee of a nursing home or any group-care home where the declarant resides. I further state that I do not now have any claim against the declarant.

Witness: _____

Witness: _____

Certificate

I, _____, Notary Public for _____ County hereby certify that _____, the declarant, appeared before me and swore to me and to the witnesses in my presence that this instrument is his/her Declaration Of A Desire For A Natural Death, and that he/she had willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed _____, declarant, sign the attached declaration, believing him/her to be of sound mind; and also swore that at the time they witnessed the declaration (i) they were not related within the third degree to the declarant or to the declarant's spouse, and (ii) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon the declarant's death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it provides at that time, and (iii) they were not a physician attending the declarant or an employee of an attending physician or an employee of a health facility in which the declarant was a patient or an employee of a nursing home or any group-care home in which the declarant resided, and (iv) they did not have a claim against the declarant. I further certify that I am satisfied as to the genuineness and due execution of the declaration.

This the _____ day of _____, 20____.

Notary Public for the County of _____

Commission expires:_____