INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE (PART I)

DISCLOSURE STATEMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING IT, YOU SHOULD KNOW THESE IMPORTANT FACTS:
Except to the extent you state 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. "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, 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 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 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. If for moral or religious reasons you do not want to be treated by a doctor or 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 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 and 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 had, 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 may 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.

DISCLOSURE STATEMENT (CONTINUED)

The person you appoint 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 registered nurse practitioner, 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 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 registered nurse practitioner 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 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 ARNP'S 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.

DISCLOSURE STATEMENT (CONTINUED)

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 ARNP, or person acting under the direction or control of the attending physician or ARNP;

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

PART I: NEW HAMPSHIRE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME

I, _____,
(name)

PRINT THE NAME AND ADDRESS OF YOUR AGENT

hereby appoint _____
(name of agent)

of _____
(address)

_____

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 an alternate agent)

PRINT THE NAME AND ADDRESS OF YOUR ALTERNATE AGENT

of _____
(address)

_____

as alternate agent.

When making health care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this advance directive, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE DECISIONS.

INSTRUCTION STATEMENTS

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: 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.

INITIAL THE RESPONSES THAT REFLECT YOUR WISHES

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

   INITIAL ONLY ONE CHOICE

   ____(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:

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

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

   INITIAL ONLY ONE CHOICE

   OR

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

B. MEDICALLY ADMINISTERED NUTRITION AND HYDRATION.

1. I realize that situations could arise in which the only way to allow me to die would be to not start or to discontinue medically administered nutrition and hydration. In carrying out any instructions I have given in this document, I authorize my agent to direct that:

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

   ____(a) medically administered nutrition and hydration not be started or, if started, be discontinued.

   INITIAL ONLY ONE CHOICE

   OR

   ____(b) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

C. ADDITIONAL INSTRUCTIONS.

Here you may include any specific desires or limitations you deem appropriate, such as 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)

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 document will be kept at: _____, and the following persons and institutions will have signed copies:

_____
Name

_____
Address

_____
Name

_____
Address

LOCATION OF THE ORIGINAL AND COPIES

PRINT THE DATE

PRINT YOUR NAME

PART II. NEW HAMPSHIRE DECLARATION

Declaration made this _____ day of _____.
(day) (month, year)

I, _____,
(name)
being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease or illness and I am certified to be near death or in a permanently unconscious condition by 2 physicians or a physician and an ARNP, and two physicians or a physician and an ARNP have determined that my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or that I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the natural ingestion of food or fluids by eating or drinking, or the performance of any medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue medically administered nutrition and hydration.

In carrying out any instruction I have given under this section, I authorize that:

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

INITIAL ONLY ONE CHOICE

____(a) medically administered nutrition and hydration not be started or, if started, be discontinued,

OR

____(b) even if other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

ADD ADDITIONAL INSTRUCTIONS, IF ANY

NOTE: PART II IS ONLY EFFECTIVE TO STATE A DECISION TO WITHHOLD OR WITHDRAW LIFE-SUSTAINING TREATMENTS IF YOU ARE NEAR DEATH OR PERMENANTLY UNCONSCIOUS.

BECAUSE PART II IS LIMITED IN THIS WAY, IF YOU PLAN TO COMPLETE PART I, YOU MAY WISH TO LEAVE PART II BLANK AND RECORD YOUR ADVANCE PLANNING WISHES IN PART I.

Other directions:

In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and health care providers as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full meaning and significance of this declaration, and I am emotionally and mentally competent to make this declaration.

PART III: EXECUTION

This advance directive will not be valid unless it is EITHER:

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE WITNESSED, USE ALTERNATIVE NO. 1, BELOW (P. 15)

Alternative No. 1: Signed by two (2) adult witnesses who are present when you sign or acknowledge your signature.

Neither of your witnesses **can be**:

- your agent,
- your spouse,
- your heir or any person entitled to any part of your estate either under your last will and testament or by operation of law,
- your attending physician or ARNP, or person acting under the direction and control of your attending physician or ARNP.

In addition, one of your witnesses **cannot** be:

- your health or residential care provider, or an employee of your health or residential care provider

OR

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE NOTARIZED, USE ALTERNATIVE NO. 2, BELOW (P. 16)

Alternative No. 2: Witnessed by a notary public or justice of the peace

Alternative No. 1: Sign before witnesses.

I sign my name to this Advance Directive on
_____ at _____,_____.
(date) (city) (state)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

_____
(signature)

_____
(print name)

WITNESS ATTESTATION

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 he or she is aware of the nature of the advance directive and is signing it freely and voluntarily.

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness 1:

Signature: _____Date_____

Print Name: _____

Residence Address: _____

Witness 2:

Signature: _____Date_____

Print Name: _____

Residence Address: _____

Alternative No. 2: Sign before a notary public or justice of the peace.

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

I sign my name to this Advance Directive on _____ at _____, _____.
(date) (city) (state)

_____
(signature)

_____
(print name)

A NOTARY PUBLIC OR JUSTICE OF THE PEACE MUST COMPLETE THIS SECTION

CERTIFICATE OF ACKNOWLEDGMENT OF 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:_____