PRINT YOUR NAME

PRINT YOUR AGENT'S AND SUCCESSOR AGENTS' NAMES, ADDRESSES AND TELEPHONE NUMBERS

'

NAME THE PHYSICIAN(S) WHO YOU WANT TO DETERMINE THAT YOU CAN NO LONGER MAKE HEALTH CARE DECISIONS

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 heath care shall be made by my attending physician.

ADDITIONAL EXPLANATION

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 5 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.

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.

ADDITIONAL EXPLANATION (CONTINUED)

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.

INITIAL AND COMPLETE THE BLOCKS BELOW ONLY IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY

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.** You may attach additional pages, if needed.)

A. Limitations about Artificial Nutrition or Hydration.

In exercising the authority to make health care decisions on my behalf, my health care agent:

IF YOU INITIAL EITHER BLOCK HERE, BUT DO NOT INSERT ANY SPECIAL PROVISIONS, YOUR HEALTH CARE AGENT SHALL HAVE NO AUTHORITY TO WITHHOLD ARTIFICIAL NUTRITION OR HYDRATION

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

_____

_____

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

_____

_____

B. Limitations Concerning Health Care Decisions.

INITIAL HERE IF YOU WANT TO ADD LIMITATIONS ON YOUR AGENT'S AUTHORITY

YOU MUST LIST THE LIMITATIONS IF YOU INITIAL THIS BLOCK

_____ 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.)

_____

_____

INITIAL HERE IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY TO MAKE MENTAL HEALTH DECISIONS FOR YOU

YOU MUST LIST THE LIMITATIONS, IF YOU INITIAL THIS BLOCK

INITIAL HERE IF YOU WANT TO ADD INSTRUCTIONS FOR MENTAL HEALTH TREATMENT

YOU MUST LIST MENTAL HEALTH INSTRUCTIONS IF YOU INITIAL THIS BLOCK

INITIAL HERE IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY TO ARRANGE FOR THE FINAL DISPOSITION DECISIONS FOR YOU

YOU MUST LIST THE LIMITATIONS IF YOU INITIAL THIS BLOCK

C. 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.)

_____

_____

D. Advance Instruction for Mental Health Treatment.

_____ (Notice: 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):

_____

_____

E. Autopsy and Disposition of Remains.

_____ In exercising the 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):

_____

_____

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 ONLY ONE

_____ Donate any needed organs or parts; or

_____ Donate only the following organs or parts:

_____

_____

INITIAL HERE TO ALLOW YOUR AGENT TO DONATE YOUR BODY TO SCIENCE

_____ Donate my body for anatomical study if needed.

YOU MUST LIST THE LIMITATIONS IF YOU INITIAL THIS BLOCK

_____ 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.)

_____

_____

_____

_____

_____

_____

_____

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

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.

ADDITIONAL EXPLANATION

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.

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.

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

10. Additional Instructions

My agent should also consider the following instructions in making decisions on my behalf:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Attach additional pages, if needed.)

11. I Understand the Effect of this Health Care Power of Attorney.

By executing this document in Part III, 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.

PART II: ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL")

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.

GENERAL INSTRUCTIONS

GENERAL INSTRUCTIONS: You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care 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, clergypersons, and lawyers before you complete and sign this Living Will.

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

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.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.secretary.state.nc.us/ahcdr/Forms.aspx.

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.

INITIAL THE CONDITION OR CONDITIONS UNDER WHICH YOU WANT YOUR LIVING WILL TO BE OPERATIVE

_____ 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 (initial only one):

INITIAL ONLY ONE

_____ MAY withhold or withdraw life-prolonging measures.

_____ SHALL withhold or withdraw life-prolonging measures.

INITIAL A CHOICE IN SECTION 3 ONLY IF YOU WANT TO MAKE AN EXCEPTION TO YOUR INSTRUCTIONS IN SECTION 2

INITIAL ONLY ONE

3. Exceptions – "Artificial Nutrition or Hydration"

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1 (initial only one):

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

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

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

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.

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 (Part I) 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 only one. 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):

INITIAL ONLY ONE

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

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

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

7. Additional Instructions

I further direct that:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

8. 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.

9. I Want this Directive to be Effective Anywhere

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

10. 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.

PART III: EXECUTION

SIGN AND DATE AND PRINT YOUR NAME HERE

_____ _____
Signature Date

I hereby state that the principal/declarant, _____(your name), being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing advance directive 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.

WITNESSES

YOUR TWO WITNESSES MUST PRINT THEIR NAMES, DATE, AND SIGN HERE

Witness 1 name: _____

Date: _____ Witness Signature: _____

Witness 2 name: _____

Date: _____ Witness Signature: _____

NOTARY PUBLIC

AND

_____COUNTY, _____STATE

A NOTARY PUBLIC MUST COMPLETE THIS PART OF YOUR DOCUMENT

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)

Date: _____ _____
(Official Seal) Signature of Notary Public

_____, Notary Public
Printed or typed name

My commission expires: _____