An Advance Directive
For North Carolina

A Practical Form for All Adults

Introduction

This form allows you to express your wishes for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.

If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form has three parts. You may complete Part A only, or Part B only, or both Parts A and B. To make this advance directive legally effective, you must complete Part C of this form. Please keep all five pages of this form together and include all five pages of the form in any copies you may share with your loved ones or health care providers.

This form complies with North Carolina law (in NCGS § 32A-15 through 32A-27 and § 90-320 through 90-322).

Part A: Health Care Power of Attorney

1. **What is a health care power of attorney?** A health care power of attorney is a legal document in which you name another person, called a "health care agent," to make health care decisions for you when you are not able to make those decisions for yourself.
2. **Who can be a health care agent?** Any competent person who is at least 18 years old and who is not your paid health care provider may be your health care agent.
3. **How should you choose your health care agent?** You should choose your health care agent very carefully, because that person will have broad authority to make decisions about your health care. A good health care agent is someone who knows you well, is available to represent you when needed, and is willing to honor your wishes. It is very important to talk with your health care agent about your goals and wishes for your future health care, so that he or she will know what care you want.
4. **What decisions can your health care agent make?** Unless you limit the power of your health care agent in Section 2 of Part A of this form, your health care agent can make <u>all</u> health care decisions for you, including:
   - starting or stopping life-prolonging measures
   - decisions about mental health treatment
   - choosing your doctors and facilities
   - reviewing and sharing your medical information
   - autopsies and disposition of your body after death
5. **Can your health care agent donate your organs and tissues after your death?** Yes, if you choose to give your health care agent this power on the form. To do this, you must initial the statement in Section 3 of Part A.
6. **When will this health care power of attorney be effective?** This document will become effective if your doctor determines that you have lost the ability to make your own health care decisions.

7. **How can you revoke this health care power of attorney?** If you are competent, you may revoke this health care power of attorney in any way that makes clear your desire to revoke it. For example, you may destroy this document, write "void" across this document, tell your doctor that you are revoking the document, or complete a new health care power of attorney.
8. **Who makes health care decisions for me if I don't name a health care agent and I am not able to make my own decisions?** If you do not have a health care agent, NC law requires health care providers to look to the following individuals, in the order listed below: legal guardian; an attorney-in-fact under a general power of attorney (POA) if that POA includes the right to make health care decisions; a husband or wife; a majority of your parents and adult children; a majority of your adult brothers and sisters; or an individual who has an established relationship with you, who is acting in good faith and who can convey your wishes. If there is no one, the law allows your doctor to make decisions for you as long as another doctor agrees with those decisions.

Part B: Living Will

1. **What is a living will?** In North Carolina, a living will lets you state your desire not to receive life-prolonging measures in any or all of the following situations:
   - You have a condition that is incurable that will result in your death within a short period of time.
   - You are unconscious, and your doctors are confident that you cannot regain consciousness.
   - You have advanced dementia or other substantial and irreversible loss of mental function.
2. **What are life-prolonging measures?** Life-prolonging measures are medical treatments that would only serve to postpone death, including breathing machines, kidney dialysis, antibiotics, tube feeding (artificial nutrition and hydration), and similar forms of treatment.
3. **Can life-prolonging measures be withheld or stopped without a living will?** Yes, in certain circumstances. If you are able to express your wishes, you may refuse life-prolonging measures. If you are not able to express your wishes, then permission must be obtained from those individuals who are making decisions on your behalf.
4. **What if you want to receive tube feeding (artificial nutrition and hydration)?** You may express your wish to receive tube feeding in all circumstances. To do this, you must initial the statement in Section 2 of Part B.
5. **How can you revoke this living will?** You may revoke this living will by clearly stating or writing in any clear manner that you wish to do so. For example, you may destroy the document, write "void" across the document, tell your doctor that you are revoking the document, or complete a new living will.

Part C: Completing this Document

To make this advance directive legally effective, all three sections of Part C of the document must be completed.

1. Wait until two witnesses and a notary public are present, then sign and date the document.
2. Two witnesses must sign and date the document in Section 2 of Part C. These witnesses cannot be:
   - related to you by blood or marriage,
   - your heir, or a person named to receive a portion of your estate in your will,
   - someone who has a claim against you or against your estate, or
   - your doctor, other health care provider, or an employee of a hospital in which you are a patient, or an employee of the nursing home or adult care home where you live.
3. A notary public must witness these signatures and notarize the document in Section 3 of Part C.

Part A: Health Care Power of Attorney (Choosing a Health Care Agent)

If you do not wish to appoint a health care agent, strike through this entire part and initial here _____.

My name is: _____ **My birth date is**: ___/___ /_____
(Please Print)

1. The person I choose as my health care agent is:

first name	middle name	last name	
street address	city	state	zip code
home phone	work phone	cell phone	e-mail address

If this person is unable or unwilling to serve as my health care agent, my next choice is:

first name	middle name	last name	
street address	city	state	zip code
home phone	work phone	cell phone	e-mail address

2. Special Instructions:

NOTE: In this section, you may include **any special instructions** you want your health care agent to follow, or **any limitations** you want to put on the decisions your health care agent can make, including decisions about tube feeding, other life-prolonging treatments, mental health treatments, autopsy, disposition of your body after death, and organ donation.

If you do not have any special instructions for your health care agent, or any limitations you want to put on your agent's authority, please draw a line through this section.

_____

_____

_____

_____

_____

_____

3. Organ Donation:

_____ (initial) My health care agent may donate my organs, tissues, or parts after my death.

(Please note: if you do not initial above, your health care agent will not be able to donate your organs or parts.)

Part B: Living Will

If you do not wish to prepare a living will, strike through this entire part and initial here_____ .

My name is: _____ **My birth date is**: ___/___ /_____
(Please Print)

1. If I am unable to make or communicate health care decisions, I desire that my life not be prolonged by life-prolonging measures in the following situations (you may initial <u>any or all</u> of these choices)**:**

_____ (initial) I have a condition that cannot be cured and that will result in my death within a relatively short period of time.

_____ (initial) I become unconscious and my doctors determine that, to a high degree of medical certainty, I will never regain my consciousness.

_____ (initial) I suffer from advanced dementia or any other condition which results in the substantial loss of my ability to think, and my doctors determine that, to a high degree of medical certainty, this is not going to get better.

2. _____ (initial) Even though I do not want my life prolonged by other life-prolonging measures in the situations I have initialed in section 1 above, <u>I DO</u> want to receive tube feeding in those situations (initial here <u>only</u> if you **DO** want tube feeding in those situations)**.**

3. I wish to be made as comfortable as possible. I want my health care providers to keep me as clean, comfortable, and free of pain as possible, even though this care may hasten my death.

4. My health care providers may rely on this living will to withhold or discontinue life-prolonging measures in the situations I have initialed above.

5. If I have appointed a health care agent in Part A of this advance directive or a similar document, and that health care agent gives instructions that differ from the desires expressed in this living will, then: (NOTE: initial **ONLY ONE** of the two choices below)**:**

_____ (initial) **Follow this living will.** My health care agent cannot make decisions that are different from what I have stated in this living will.

_____ (initial) **Follow health care agent:** My health care agent has the authority to make decisions that are different from what I have indicated in this living will.

Part C: Completing this Document (wait until two witnesses and a notary public are present before you sign!)

1. Your Signature

I am mentally alert and competent, and I am fully informed about the contents of this document.

Date: _____

Signature: _____

2. Signatures of Witnesses

I hereby state that the person named above, _____ , being of sound mind, signed (or directed another to sign on the person's behalf) the foregoing document in my presence. I am not related to the person by blood or marriage, and I would not be entitled to any portion of the estate of the person under any existing will or codicil of the person or as an heir under the law, if the person died on this date without a will. I am not the person's attending physician. I am not a licensed health care provider or mental health treatment provider who is (1) an employee of the person's attending physician or mental health treatment provider, (2) an employee of the health facility in which the person is a patient, or (3) an employee of a nursing home or any adult care home where the person resides. I do not have any claim against the person or the estate of the person.

Date: _____ Signature of Witness: _____

Date: _____ Signature of Witness: _____

3. Notarization

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by

_____ *(type/print name of signer)*

_____ *(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: _____