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Thank you for downloading the PDF-fillable form for your Medical Directive, Advance Medical Directive, or Medical Power of Attorney. The process is very straightforward:

1. Choose the subscription type you want and pay online. We use paypal for all credit card processing and NEVER store your Credit Card Information.
2. Download the form to your computer.
3. Fill it out on your computer and print it.
4. Take the filled-form to your favorite notary (or your witnesses) and have it notarized or witnessed.
5. Fax your paperwork to 866-300-7388. If you want to email it instead, please SCAN all to PDF utilizing 200 DPI scan settings, making 1 PDF file, and email to [forms@medicaldirectives.net](mailto:forms@medicaldirectives.net)
6. Your Retrieval Card is emailed out to you within 24 hours of receiving your medical directive. If you lose it or need another one, you can generate one easily on our web portal .

Here is the form for the state you selected. Please do not fax back any instruction sheets. We do not require a coversheet when you fax.

# North Dakota Living Will

*N.D. Cent. Code, § 23-06.4-03*

I declare on (month, day, year): \_\_\_\_\_

a. I have made the following decision concerning life-prolonging treatment (initial 1, 2, or 3):

(1)  I direct that life-prolonging treatment be withheld or withdrawn and that I be permitted to die naturally if two physicians certify that:

(a) I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death;

(b) The application of life-prolonging treatment would serve only to artificially prolong the process of my dying; and

(c) I am not pregnant.

It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and that they accept the consequences of that refusal, which is death.

(2)  I direct that life-prolonging treatment, which could extend my life, be used if two physicians certify that I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death. It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to direct that medical or surgical treatment be provided.

(3)  I make no statement concerning life-prolonging treatment.

b. I have made the following decision concerning the administration of nutrition when my death is imminent (initial only one statement):

(1)  I wish to receive nutrition.

(2)  I wish to receive nutrition unless I cannot physically assimilate nutrition, nutrition would be physically harmful or would cause unreasonable physical pain, or nutrition would only prolong the process of my dying.

(3)  I do not wish to receive nutrition.

(4)  I make no statement concerning the administration of nutrition.

c. I have made the following decision concerning the administration of hydration when my death is imminent (initial only one statement):

(1)  I wish to receive hydration.

(2)  I wish to receive hydration unless I cannot physically assimilate hydration, hydration would be physically harmful or would cause unreasonable physical pain, or hydration would only prolong the process of my dying.

(3)  I do not wish to receive hydration.

(4)  I make no statement concerning the administration of hydration.

d. Concerning the administration of nutrition and hydration, I understand that if I make no statement about nutrition or hydration, my attending physician may withhold or withdraw nutrition or hydration if the physician determines that I cannot physically assimilate nutrition or hydration or that nutrition or hydration would be physically harmful or would cause unreasonable physical pain.

e. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration is not effective during the course of my pregnancy.

f. I understand the importance of this declaration, I am voluntarily signing this declaration, I am at least eighteen years of age, and I am emotionally and mentally competent to make this declaration.

g. I understand that I may revoke this declaration at any time.

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Signed

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City, County, and State of Residence

h. Notary Public

In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

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(Signature of Notary Public)

My commission expires \_\_\_\_\_, 20\_\_\_\_.

# HEALTH CARE DIRECTIVE

I, \_\_\_\_\_, understand this document allows me to do ONE OR ALL of the following:

**PART I:** Name another person (called the health care agent) to make health care decisions for me if I am unable to make and communicate health care decisions for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or my agent must act in my best interest if I have not made my health care wishes known.

AND/OR

**PART II:** Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make and communicate decisions for myself.

AND/OR

**PART III:** Allows me to make an organ and tissue donation upon my death by signing a document of anatomical gift.

## PART I: APPOINTMENT OF HEALTH CARE AGENT

### THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS FOR MYSELF

*(I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent.)*

**NOTE:** If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II and/or Part III. *None of the following may be designated as your agent: your treating health care provider, a nonrelative employee of your treating health care provider, an operator of a long-term care facility, or a nonrelative employee of a long-term care facility.*

When I am unable to make and communicate health care decisions for myself, I trust and appoint \_\_\_\_\_ to make health care decisions for me.

This person is called my health care agent.

Relationship of my health care agent to me: \_\_\_\_\_

Telephone number of my health care agent: \_\_\_\_\_

Address of my health care agent: \_\_\_\_\_

**(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT:** If my health care agent is not reasonably available, I trust and appoint \_\_\_\_\_ to be my health care agent instead.

Relationship of my alternate health care agent to me: \_\_\_\_\_

Telephone number of my alternate health care agent: \_\_\_\_\_

Address of my alternate health care agent: \_\_\_\_\_

**THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS FOR MYSELF**

*(I know I can change these choices.)*

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to make and communicate health care decisions for myself, my health care agent has the power to:

- (A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service or procedures. This includes deciding whether to stop or not start health care that is keeping me, or might keep me, alive and deciding about mental health treatment.
- (B) Choose my health care providers.
- (C) Choose where I live and receive care and support when those choices relate to my health care needs.
- (D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I **DO NOT** want my health care agent to have a power listed above in (A) through (D) OR if I want to **LIMIT** any power in (A) through (D), I **MUST** say that here:

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My health care agent is **NOT** automatically given the powers listed below in (1) and (2). If I **WANT** my agent to have any of the powers in (1) and (2), I must **INITIAL** the line in front of the power; then my agent **WILL HAVE** that power.

\_\_\_\_(1) To decide whether to donate any parts of my body, including organs, tissues and eyes, when I die.

\_\_\_\_(2) To decide what will happen to my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

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# PART II: HEALTH CARE INSTRUCTIONS

**NOTE:** Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you **MUST** complete, at a minimum, Part II (B) if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to make and communicate health care decisions for myself. These instructions must be followed (so long as they address my needs).

## **(A) THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE**

*(I know I can change these choices or leave any of them blank.)*

I want you to know these things about me to help you make decisions about my health care.

My goals for my health care:

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My fears about my health care:

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My spiritual or religious beliefs and traditions:

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My beliefs about when life would be no longer worth living:

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My thoughts about how my medical condition might affect my family:

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**(B) THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE**

*(I know I can change these choices or leave any of them blank.)*

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics and blood transfusions. Most medical treatments can be tried for a while and then stopped, if they do not help.

I have these views about my health care in these situations:

**(Note:** You can discuss general feelings, specific treatments, or leave any of them blank.)

If I had a reasonable chance of recovery and were temporarily unable to make and communicate health care decisions for myself, I would want:

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If I were dying and unable to make and communicate health care decisions for myself, I would want:

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If I were permanently unconscious and unable to make and communicate health care decisions for myself, I would want:

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If I were completely dependent on others for my care and unable to make and communicate health care decisions for myself, I would want:

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In all circumstances, my doctors will try to keep me comfortable and reduce my pain.  
This is how I feel about pain relief, if it would affect my alertness or if it could shorten my life:

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There are other things that I want or do not want for my health care, if possible:

Who I would like to be my doctor:

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Where I would like to live to receive health care:

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Where I would like to die and other wishes I have about dying:

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My wishes about what happens to my body when I die (cremation, burial):

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Any other things:

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## PART III: MAKING AN ANATOMICAL GIFT

I would like to be an organ donor at the time of my death. I have told my family my decision and ask my family to honor my wishes. I wish to donate the following (*initial one statement*):

Any needed organs and tissue.

Only the following organs and tissue: \_\_\_\_\_

## PART IV: MAKING THE DOCUMENT LEGAL

### DATE AND SIGNATURE OF PRINCIPAL

*(YOU MUST DATE AND SIGN THIS HEALTH CARE DIRECTIVE.)*

I revoke any prior health care directive. \_\_\_\_\_  
(you sign here)

I sign my name to this Health Care Directive Form on \_\_\_\_\_ at \_\_\_\_\_, \_\_\_\_\_  
(date) (city) (state)

*(THIS HEALTH CARE DIRECTIVE WILL NOT BE VALID UNLESS IT IS NOTARIZED OR SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS HEALTH CARE DIRECTIVE.)*

### NOTARY PUBLIC OR STATEMENT OF WITNESSES

This document must be (1) notarized or (2) witnessed by two qualified adult witnesses. The person notarizing this document may be an employee of a health care or long-term care provider providing your care. At least one witness to the execution of the document must not be a health care or long-term care provider providing you with direct care or an employee of the health care or long-term care provider providing you with direct care. None of the following may be used as a notary or witness:

1. A person you designate as your agent or alternate agent;
2. Your spouse;
3. A person related to you by blood, marriage or adoption;
4. A person entitled to inherit any part of your estate upon your death; or
5. A person who has, at the time of executing this document, any claim against your estate.

### OPTION 1: NOTARY PUBLIC

In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

\_\_\_\_\_  
(Signature of Notary Public)

My commission expires \_\_\_\_\_, 20\_\_\_\_.

**OPTION 2: TWO WITNESSES**

**WITNESS ONE:**

- (1) In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
- (2) I am at least eighteen years of age.
- (3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box: [    ].

I certify that the information in (1) through (3) is true and correct.

\_\_\_\_\_  
(Signature of Witness One)

\_\_\_\_\_  
\_\_\_\_\_  
(Address)

**WITNESS TWO:**

- (1) In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
- (2) I am at least eighteen years of age.
- (3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box: [    ].

I certify that the information in (1) through (3) is true and correct.

\_\_\_\_\_  
(Signature of Witness One)

\_\_\_\_\_  
\_\_\_\_\_  
(Address)

## ACCEPTANCE OF APPOINTMENT OF HEALTH CARE AGENT

I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapacitated or if this document otherwise authorizes me to make health care decisions.

I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner.

If I choose to withdraw during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is not able to make health care decisions, I must notify the principal's physician.

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(Signature of agent/date)

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(Signature of alternate agent/date)