Sixty-fifth Legislative Assembly of North Dakota

SENATE BILL NO. 2151

Introduced by

24

Senators Holmberg, Armstrong, Myrdal

Representatives K. Koppelman, Vetter

- A BILL for an Act to amend and reenact section 23-06.5-17 of the North Dakota Century Code,
 relating to health care directives.
- 3 BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:
- 4 SECTION 1. AMENDMENT. Section 23-06.5-17 of the North Dakota Century Code is 5 amended and reenacted as follows: 6 23-06.5-17. Optional health care directive form. 7 The following is an optional form of a health care directive and is not a required form: 8 HEALTH CARE DIRECTIVE 9 , understand this document allows me to do ONE 10 OR ALL of the following: 11 PART I: Name another person (called the health care agent) to make health care decisions 12 for me if I am unable to make and communicate health care decisions for myself. My health 13 care agent must make health care decisions for me based on the instructions I provide in this 14 document (Part II), if any, the wishes I have made known to him or her, or my agent must act in 15 my best interest if I have not made my health care wishes known. 16 AND/OR 17 PART II: Give health care instructions to guide others making health care decisions for me. 18 If I have named a health care agent, these instructions are to be used by the agent. These 19 instructions may also be used by my health care providers, others assisting with my health care 20 and my family, in the event I cannot make and communicate decisions for myself. 21 AND/OR 22 PART III: Allows me to make an organ and tissue donation upon my death by signing a 23 document of anatomical gift.

PART I: APPOINTMENT OF HEALTH CARE AGENT

ı	THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS					
2	FOR ME IF I AM UNABLE TO MAKE AND COMMUNICATE					
3	HEALTH CARE DECISIONS FOR MYSELF					
4	(I know I can change my agent or alternate agent at any time					
5	and I know I do not have to appoint an agent or an alternate agent)					
6	NOTE: If you appoint an agent, you should discuss this health care directive with your agent					
7	and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank					
8	and go to Part II and/or Part III. None of the following may be designated as your agent: your					
9	treating health care provider, a nonrelative employee of your treating health care provider, an					
10	operator of a long-term care facility, or a nonrelative employee of a long-term care facility.					
11	When I am unable to make and communicate health care decisions for myself, I trust and					
12	appoint to make health care decisions for me. This person					
13	is called my health care agent.					
14	Relationship of my health care agent to me:					
15	Telephone number of my health care agent:					
16	Address of my health care agent:					
17	(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT: If my					
18	health care agent is not reasonably available, I trust and appoint					
19	to be my health care agent instead.					
20	Relationship of my alternate health care agent to me:					
21	Telephone number of my alternate health care agent:					
22	Address of my alternate health care agent:					
23	THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO					
24	IF I AM UNABLE TO MAKE AND COMMUNICATE HEALTH CARE DECISIONS					
25	FOR MYSELF					
26	(I know I can change these choices)					
27	My health care agent is automatically given the powers listed below in (A) through (D). My					
28	health care agent must follow my health care instructions in this document or any other					
29	instructions I have given to my agent. If I have not given health care instructions, then my agent					
30	must act in my best interest.					

1	Whenever I am unable to make and communicate health care decisions for myself, my					
2	health care agent has the power to:					
3	(A) Make any health care decision for me. This includes the power to give, refuse, or					
4	withdraw consent to any care, treatment, service, or procedures. This includes deciding whether					
5	to stop or not start health care that is keeping me or might keep me alive and deciding about					
6	mental health treatment.					
7	(B) Choose my health care providers.					
8	(C) Choose where I live and receive care and support when those choices relate to my					
9	health care needs.					
10	(D) Review my medical records and have the same rights that I would have to give my					
11	medical records to other people.					
12	If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR					
13	if I want to LIMIT any power in (A) through (D), I MUST say that here:					
14						
15						
16						
17	My health care agent is NOT automatically given the powers listed below in (1) and (2). If I					
18	WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the					
19	power; then my agent WILL HAVE that power.					
20	(1) To decide whether to donate any parts of my body, including organs, tissues, and					
21	eyes, when I die.					
22	(2) To decide what will happen with my body when I die (burial, cremation).					
23	If I want to say anything more about my health care agent's powers or limits on the powers,					
24	I can say it here:					
25						
26						
27						
28	PART II: HEALTH CARE INSTRUCTIONS					
29	NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an					
30	agent in Part I, completing this Part II is optional but would be very helpful to your agent					

1	However, if you chose not to appoint an agent in Part I, you MUST complete, at a minimum,					
2	Part II (B) if you wish to make a valid health care directive.					
3	These are instructions for my health care when I am unable to make and communicate					
4	health care decisions for myself. These instructions must be followed (so long as they address					
5	my needs).					
6	(A) THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE					
7	(I know I can change these choices or leave any of them blank)					
8	I want you to know these things about me to help you make decisions about my health care:					
9	My goals for my health care:					
10						
11						
12						
13	My fears about my health care:					
14						
15						
16						
17	My spiritual or religious beliefs and traditions:					
18						
19						
20						
21	My beliefs about when life would be no longer worth living:					
22						
23						
24						
25	My thoughts about how my medical condition might affect my family:					
26						
27						
28	(D) THIS IS MULAT I MANT AND DO NOT MANT FOR ANY LIFE TO SEE					
29	(B) THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE					
30	(I know I can change these choices or leave any of them blank)					

1	Many medical treatments may be used to try to improve my medical condition or to prolong					
2	my life. Examples include artificial breathing by a machine connected to a tube in the lungs,					
3	artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis,					
4	antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then					
5	stopped if they do not help.					
6	I have these views about my health care in these situations:					
7	(Note: You can discuss general feelings, specific treatments, or leave any of them blank).					
8	If I had a reasonable chance of recovery and were temporarily unable to make and					
9	communicate health care decisions for myself, I would want:					
0						
11						
2						
3	If I were dying and unable to make and communicate health care decisions for myself, I					
4	would want:					
5						
6						
7						
8	If I were permanently unconscious and unable to make and communicate health care					
9	decisions for myself, I would want:					
20						
21						
22						
23	If I were completely dependent on others for my care and unable to make and communicate					
24	health care decisions for myself, I would want:					
25						
26						
27						
28	In all circumstances, my doctors health care providers will try to keep me comfortable and					
29	reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could					
30	shorten my life:					
31						

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1	
3	There are other things that I want or do not want for my health care, if possible:
4	Who I would like to be my doctor health care provider:
5	
6	
7	
8	Where I would like to live to receive health care:
9	
0	
11	
2	Where I would like to die and other wishes I have about dying:
3	
4	
5 6	My wishes shout what happens to my hady when I dis (gramation, buris):
7	My wishes about what happens to my body when I die (cremation, burial):
8	
9	
20	Any other things:
21	, and cancer annually
2	
23	
24	PART III: MAKING AN ANATOMICAL GIFT
25	(A) I WANT TO BE AN ORGAN DONOR
26	[] I would like to be an organ donor at the time of my death. I have told my family my
27	decision and ask my family to honor my wishes. I wish to donate the following (initial one
28	statement):
29	[] Any needed organs and tissue.
0	[] Only the following organs and tissue:
31	(B) I DO NOT WANT TO BE AN ORGAN DONOR

I	[] I do not want to be an organ donor at the time of my death. I have told my family my decision					
2	and ask my family to honor my wishes.					
3	PART IV: MAKING THE DOCUMENT LEGAL					
4	PRIOR DESIGNATIONS REVOKED. I revoke any prior health care directive.					
5	DATE AND SIGNATURE OF PRINCIPAL					
6	(YOU MUST DATE AND SIGN THIS HEALTH CARE DIRECTIVE)					
7	I sign my name to this Health Care Directive Form on at					
8	(date)					
9						
10	(city)					
11						
12	(state)					
13						
14	(you sign here)					
15	(THIS HEALTH CARE DIRECTIVE WILL NOT BE VALID UNLESS IT IS NOTARIZED OR					
16	SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR					
17	ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES					
18	TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE					
19	SAME TIME YOU DATE AND SIGN THIS HEALTH CARE DIRECTIVE.)					
20	NOTARY PUBLIC OR STATEMENT OF WITNESSES					
21	This document must be (1) notarized or (2) witnessed by two qualified adult witnesses. The					
22	person notarizing this document may be an employee of a health care or long-term care					
23	provider providing your care. At least one witness to the execution of the document must not be					
24	a health care or long-term care provider providing you with direct care or an employee of the					
25	health care or long-term care provider providing you with direct care. None of the following may					
26	be used as a notary or witness:					
27	 A person you designate as your agent or alternate agent; 					
28	2. Your spouse;					
29	3. A person related to you by blood, marriage, or adoption;					
30	4. A person entitled to inherit any part of your estate upon your death; or					

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1	5. A person who has, at the time of executing this document, any claim against your						
2		est	ate.				
3				Option	1: Notary Public		
4	State of						
5	County o	of					
6	In my pr	eser	nce on	_ (date),		(name of declara	ant) acknowledged
7	the decl	aran	t's signature on t	his documen	t or acknowledg	ged that the decl	larant directed the
8	person s	ignir	ng this document to	o sign on the	declarant's beha	alf.	
9				-			
10	(Signatu	re of	Notary Public)				
11	My comr	niss	ion expires		, 20	0	
12				Option 2	2: Two Witnesses	;	
13	Witness	One					
14		(1)	In my presence of	on	_ (date),		(name of
15			declarant) ackno	wledged the	declarant's signa	ature on this docu	iment or
16			acknowledged th	nat the declar	ant directed the	person signing th	is document to
17			sign on the decla	arant's behalf			
18		(2)	I am at least eigh	nteen years o	of age.		
19		(3)	If I am a health c	are provider	or an employee	of a health care p	rovider giving
20			direct care to the	declarant, I	must initial this b	ox: [].	
21			I certify that the i	nformation in	(1) through (3) i	s true and correc	t.
22					_		
23			(Signature of Wit	iness One)			
24							
25			(Address)				
26	Witness	Two	:				
27		(1)	In my presence of	on	(date),		(name of
28			declarant) ackno	wledged the	declarant's signa	ature on this docu	iment or
29	acknowledged that the declarant directed the person signing this document to						
30			sign on the decla	arant's behalf			
31		(2)	I am at least eigh	nteen years o	of age.		

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1	(3)	If I am a health care	e provider or an e	employee of a health care provider giving		
2		direct care to the de	eclarant, I must ir	nitial this box: [].		
3		I certify that the info	ormation in (1) the	rough (3) is true and correct.		
4		,	()			
5		(Signature of Witnes	ss Two)			
6			<i>,</i>			
7		(Address)				
8	ACCEPTANO	E OF APPOINTMEN	IT OF POWER (OF ATTORNEY. I accept this appointment and		
9	agree to serv	e as agent for health	care decisions.	I understand I have a duty to act consistently		
0	with the des	ires of the principal	as expressed	in this appointment. I understand that this		
11	document giv	ves me authority ove	er health care do	ecisions for the principal only if the principal		
2	becomes incapacitated. I understand that I must act in good faith in exercising my authority					
3	under this power of attorney. I understand that the principal may revoke this power of attorney at					
4	any time in any manner.					
5	If I choose to withdraw during the time the principal is competent, I must notify the principal					
6	of my decision. If I choose to withdraw when the principal is not able to make health care					
7	decisions, I n	nust notify the princip	al's physician.			
8						
9				(Signature of agent/date)		
20						
21				(Signature of alternate agent/date)		
22			PRINCIPAL'S S	TATEMENT		
23	I have re	ad a written explanati	ion of the nature	and effect of an appointment of a health care		
24	agent that is	attached to my health	n care directive.			
25	Dated thi	s day of	, 20	·		
26				(Signature of Principal)		