DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For

North Carolina Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For North Carolina Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The North Carolina legislature has designed both a living will and a Power of Attorney for Health Care for use by the public. As the documents were designed specifically by state government, each should be in full compliance with all applicable statutes and laws.

At the opening of each form is an introduction that summarizes the scope and purpose of the document, as well as providing directions for its completion. Read both of them carefully to ensure that the related documents are fully and properly filled out.

***Understanding Your Directive*:**

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to speak due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want, if you cannot speak for yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation, or **3**) *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *only at the time of first completion*. Any scope-of-authority changes needed *after* your directive has been witnessed must be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then complete, sign, date, witness and/or notarize the document with the limitations and exclusions as you have described them.

Remember, unless you direct otherwise, this directive will **only** be used to guide your

family and doctors if you are unable to make medical choices and communicate treatment decisions for yourself.

Finally, some questions in this directive may be difficult to answer. However, the answers to these challenging questions may well be decided by someone else if they are not decided by you, now.

Instructions for Completing the Directive:

This directive is written in two parts – a living will and a health care power of attorney – and combined into a single "advance directive" as provided for in relevant North Carolina statutes *(§32A-25.4.c, and §90-322(j))*. While it is best if you fill out the whole document, you may choose to complete just ***Section I***, leaving only a statement of your values and wishes. Or you may complete just ***Section II***, naming only someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions in your behalf. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices for you. So, you are strongly encouraged to complete the entire directive.

To complete the document, you should ***initial*** in the underlined spaces provided beside all the questions asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

If there is anything in this Directive you do not understand, you should read the Guidebook, ask your physician or a health care professional, or call an attorney for help.

SECTION I:
LIVING WILL DECLARATION
Declaration of a Desire for a Natural Death
(*Pursuant to NC Statutes §90-320 to §90-323***)**

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1. INTRODUCTION: *North Carolina Declaration statutes allow you to write out authoritative and binding wishes about the kind of medical care you would or would not want in two specific situations: 1) a terminal condition, and/or 2) a "persistent vegetative" state. A terminal condition consists of an incurable disease, illness or injury from which death would be an expected outcome. A persistent vegetative state is "a medical condition whereby in the judgment of the attending physician the patient suffers from a sustained complete loss of self-aware cognition and, without the use of extraordinary means or artificial nutrition and hydration, [the person] will succumb to death within a short time" (§90-321a-4). "Extraordinary means" is defined as "any medical procedure or intervention which...would serve only to postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function"(§90-321a-2).*

2. I have chosen *not* to complete a Living Will at this time, but I *do* want to complete a comprehensive Health Care Power of Attorney (*skip to page 5*):

Signature: _____ Date: _____

OR,

(As specifically appears in the North Carolina Statutes:)

3. I, _____, being of sound mind, desire that my wishes, as specified below, my life not be prolonged by extraordinary means or by artificial nutrition or hydration if my condition is determined to be terminal and incurable or if I am diagnosed as being in a persistent vegetative state. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means or artificial nutrition or hydration, in accordance with my specifications set forth below:

Specific Treatment Directions

(*initial any of the following, as desired*)

4. If my condition is determined to be terminal and incurable, I authorize the following:
   a. _____ My physician may withhold or discontinue extraordinary means only.
   b. _____ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.
5. If my physician determines that I am in a persistent vegetative state, I authorize the following:
   a. _____ My physician may withhold or discontinue extraordinary means only.
   b. _____ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

6. This the _____ day of _____, 20_____

Signed:_____ Date: _____

At: (City) _____ (State) _____

Statement of Witnesses

7. I hereby state that the declarant, _____, being of sound mind signed the above declaration in my presence and that I am not related to the declarant by blood or marriage and that I do not know or have a reasonable expectation that I would 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 or an employee of the declarant's attending physician, or an employee of a health facility in which the declarant is a patient or an employee of a nursing home or any group-care home where the declarant resides. I further state that I do not now have any claim against the declarant.

8. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

9. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

Declaration Certification

10. (*The clerk or the assistant clerk, or a notary public may, upon proper proof, certify the declaration as follows*:)

I, _____,
Clerk (or Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate)
for _____ County, hereby certify
that _____, the declarant, appeared
before me and swore to me and to the witnesses in my presence that this instrument is his Declaration Of A Desire For A Natural Death, and that he had willingly and voluntarily made and executed it as his free act and deed for the purposes expressed in it.
I further certify that _____, and
_____, witnesses, appeared before me and
swore that they witnessed _____, the
declarant, sign the attached declaration, believing him to be of sound mind; and also swore that at the time they witnessed the declaration (*i*) they were not related within the third degree to the declarant or to the declarant's spouse, and (*ii*) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon the declarant's death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it provides at that time, and (*iii*) they were not a physician attending the declarant or an employee of an attending physician or an employee of a health facility in which the declarant was a patient or an employee of a nursing home or any group-care home in which the declarant resided, and (*iv*) they did not have a claim against the declarant. I further certify that I am satisfied as to the genuineness and due execution of the declaration.

This the _____ day of _____, 20_____.
Clerk (or Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate)
for the County of _____.

SECTION II:
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

(*Pursuant to NC Statutes Ch. 32A:Art. 2:§32A-8 – §32A-26*)

11. *Introduction*: This section lets you name a person (a "health care agent") to make health care decisions for you if you cannot make or communicate them for yourself.

12. *Mandatory North Carolina Preface*:

NOTICE: This document gives the person you designate your health care agent broad powers to make health care decisions, including mental health treatment decisions, for you. Except to the extent that you express specific limitations or restrictions on the authority of your health care agent, this power includes the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive, admit you to a facility, and administer certain treatments and medications. This power exists only as to those health care decisions for which you are unable to give informed consent.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will have to use due care to act in your best interests and in accordance with this document. For mental health treatment decisions, your health care agent will act according to how the health care agent believes you would act if you were making the decision. Because the powers granted by this document are broad and sweeping, you should discuss your wishes concerning life-sustaining procedures, mental health treatment, and other health care decisions with your health care agent.

Use of this form in the creation of a health care power of attorney is lawful and is authorized pursuant to North Carolina law. However, use of this form is an optional and nonexclusive method for creating a health care power of attorney and North Carolina law does not bar the use of any other or different form of power of attorney for health care that meets the statutory requirements.

Designation of Health Care Agent

13. I, _____,
being of sound mind, do hereby appoint ~~

Name of Agent: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

~~ as my health care attorney-in-fact (herein referred to as my "health care agent") 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.

Alternate Agent(s) Appointment

14. If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: (Optional)

a. **Name of Alternate #1:**_____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

b. **Name of Alternate #2:** _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

15. *Effectiveness of appointment*.

NOTICE: This health care power of attorney may be revoked by you at any time in any manner by which you are able to communicate your intent to revoke to your health care agent and your attending physician.)

Absent revocation, the authority granted in this document shall become effective when and if the physician or physicians designated below determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my death. This determination shall be made by the following physician or physicians. For decisions related to mental health treatment, this determination shall be made by the following physician or eligible psychologist. (*You may include here a designation of your choice, including your attending physician or eligible psychologist, or any other physician or eligible psychologist. You may also name two or more physicians or eligible psychologists, if desired, both of whom must make this determination before the authority granted to the health care agent becomes effective.*):

_____
_____
_____
_____

16. *General statement of authority granted*. (As specifically appears in the North Carolina Statutes:)

Except as indicated in section 16 below, I hereby grant to my health care agent named above full power and authority to make health care decisions, including mental health treatment decisions, on my behalf, including, but not limited to, the following:

a. To request, review, and receive 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. To employ or discharge my health care providers.

c. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution.

d. To consent to and authorize my admission to and retention in a facility for the care or treatment of mental illness.

e. To consent to and authorize the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment".

f. To give consent for, to withdraw consent for, or to withhold 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, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain.

g. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. Life-sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain. (*Initial the clause below to activate this authority*)

_____ I DESIRE THAT MY LIFE NOT BE PROLONGED BY LIFE-SUSTAINING PROCEDURES IF I AM TERMINALLY ILL, PERMANENTLY IN A COMA, SUFFER SEVERE DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE STATE.

h. To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains.

i. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

17. *Special provisions and limitations*.

NOTICE: The above grant of power 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. If you wish to limit the scope of your health care agent's powers, you may do so in this section.

a. 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 and limitations (*Here you may include any specific limitations you deem appropriate such as: your own definition of when life-sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or unacceptable to you for any other reason*.):

_____
_____
_____
_____
_____
_____
_____
_____

b. 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 and limitations. (*Here you may include any specific limitations 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*):

_____
_____
_____
_____
_____
_____
_____
_____

c. **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 sufficient understanding or capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions about 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.):

_____
_____
_____
_____
_____
_____

18. *Guardianship provision*.

If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document 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)*.

19. *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 by my health care agent.

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 act 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.

20. *Miscellaneous provisions*.

a. I revoke any prior health care power of attorney.

b. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs.

c. 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, and assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence.

d. No act or omission of my health care agent, or of any other person, 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, 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.

21. *Signature of principal*.
By signing here, 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.

22. Signed:_____ Date: _____

At: (City) _____ (State) _____

Statement and Signatures of Witnesses

23. I hereby state that the Principal, _____, being of sound mind, signed the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor an employee of the principal's attending physician, nor an employee of the health facility in which the principal is a patient, nor an employee of a nursing home or any group care home where the principal resides. I further state that I do not have any claim against the principal.

24. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

25. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

NOTARY CERTIFICATE

26. State of NORTH CAROLINA

COUNTY of_____.

I, _____, a Notary Public for _____ County, North Carolina, hereby certify that _____ appeared before me and swore to me and to the witnesses in my presence that this instrument is a health care power of attorney, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed _____ sign the attached health care power of attorney, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his/her estate upon his/her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him/her, nor an employee of an attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of a nursing home or any group-care home in which he/she resided, and (iv) they did not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the _____day of _____, 20_____.

WITNESS my hand and official seal:

Notary Seal:

_____
Signature of Notary Public

_____
Date Commission Expires

For additional copies of this North Carolina Statutory Directive, or other related materials, please contact Lifecare Directives, LLC, at:

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