Advance Directive Form

NOTE: This form is being provided to you as a public service. The attached forms are provided "as is" and are not the substitute for the advice of an attorney. By providing these forms and information, Everplans is not providing legal advice to you. Consult an attorney if you need legal advice of any nature.

Read more and get more forms at Everplans' Advance Directive page.

Living Will: New Hampshire

LIVING WILL

Declaration made this _____ day of _____, 20_____.

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness and I am certified to be near death or in a permanently unconscious condition by 2 physicians or a physician and an APRN, and 2 physicians or a physician and an APRN have determined that my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or that I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the natural ingestion of food or fluids by eating and drinking, or the performance of any medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue medically administered nutrition and hydration.

In carrying out any instruction I have given under this section, I authorize that:
[Initial next to your choice]

_____ (1) medically administered hydration or nutrition not be started, or if started, be discontinued

<<OR>>

_____ (2) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me

In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and health care providers as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed this _____ day of _____, 2_____.

Principal's Signature: _____

[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]

Living Will: New Hampshire

THIS LIVING WILL DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time the living will is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness: _____ Address: _____

Witness: _____ Address: _____

STATE OF NEW HAMPSHIRE, COUNTY OF _____

The foregoing Living Will was acknowledged before me this _____ day of _____, 20____, by

_____ (the "Principal").

_____

Notary Public/Justice of the Peace

My commission expires _____

Durable Power of Attorney for Health Care: New Hampshire

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint _____ of _____ (Please choose only one person. If you choose more than one agent, they will have authority in priority of the order their names are listed, unless you indicate another form of decision making) as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this directive or as prohibited by law. This durable power of attorney for health care shall take effect in the event I lack the capacity to make my own health care decisions.

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint _____ of _____ as alternate agent. (Please choose only one person. If you choose more than one alternate agent, they will have authority in priority of the order their names are listed)

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE DECISIONS.

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish, you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

A. LIFE-SUSTAINING TREATMENT.

1. If I am near death and lack the capacity to make health care decisions, I authorize my agent to direct that: (Initial beside your choice of (a) or (b).)

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

<<OR>>

_____ (b) life-sustaining treatment continue to be given to me.

2. Whether near death or not, if I become permanently unconscious and life-sustaining treatment has no reasonable hope of benefit, I authorize my agent to direct that: (Initial beside your choice of (a) or (b).)

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

<<OR>>

_____ (b) sustaining treatment continue to be given to me.

B. ADDITIONAL INSTRUCTIONS.
Here you may include any specific desires or limitations you deem appropriate, such as your preferences concerning medically administered nutrition and hydration, when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or are unacceptable to you for any other reason. You may leave this question blank if you desire.

_____

_____

(attach additional pages as necessary)

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this directive. I have read and understand the information contained in the disclosure statement.

The original of this directive will be kept at _____ and the following persons and institutions will have signed copies: _____

Signed this _____ day of _____, 20_____

Principal's Signature: _____
[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]

THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness: _____ Address: _____

Witness: _____ Address: _____

STATE OF NEW HAMPSHIRE, COUNTY OF _____

The foregoing Durable Power of Attorney for Health Care was acknowledged before me

this _____ day of _____, 20_____, by _____ (the "Principal").

_____ _____
Notary Public/Justice of the Peace My commission expires