

Sixty-fifth  
Legislative Assembly  
of North Dakota

ENGROSSED SENATE BILL NO. 2151

Introduced by

Senators Holmberg, Armstrong, Myrdal

Representatives K. Koppelman, Vetter

1 A BILL for an Act to amend and reenact section 23-06.5-17 of the North Dakota Century Code,  
2 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 I \_\_\_\_\_ , 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.

24 PART I: APPOINTMENT OF HEALTH CARE AGENT

1                   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 \_\_\_\_\_

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:

10 \_\_\_\_\_  
11 \_\_\_\_\_  
12 \_\_\_\_\_

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

15 \_\_\_\_\_  
16 \_\_\_\_\_  
17 \_\_\_\_\_

18 If I were permanently unconscious and unable to make and communicate health care  
19 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 \_\_\_\_\_

1

2

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

10

11

12

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

13

14

15

16

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

17

18

19

20

Any other things:

21

22

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 decision and ask my family to honor my wishes. I wish to donate the following (initial one statement):

27

28

29

Any needed organs and tissue.

30

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

31

(B) I DO NOT WANT TO BE AN ORGAN DONOR

1 [ ] 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 1. 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

1 5. A person who has, at the time of executing this document, any claim against your  
2 estate.

3 Option 1: Notary Public

4 State of \_\_\_\_\_

5 County of \_\_\_\_\_

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

9 \_\_\_\_\_

10 (Signature of Notary Public)

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

12 Option 2: Two Witnesses

13 Witness One:

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

18 (2) I am at least eighteen years of age.

19 (3) If I am a health care provider or an employee of a health care provider giving  
20 direct care to the declarant, I must initial this box: [ ].

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

22 \_\_\_\_\_

23 (Signature of Witness One)

24 \_\_\_\_\_

25 (Address)

26 Witness Two:

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

31 (2) I am at least eighteen years of age.



1 (3) If I am a health care provider or an employee of a health care provider giving  
 2 direct care to the declarant, I must initial this box: [ ].

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

4 \_\_\_\_\_  
 5 (Signature of Witness Two)

6 \_\_\_\_\_  
 7 (Address)

8 ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY. I accept this appointment and  
 9 agree to serve as agent for health care decisions. I understand I have a duty to act consistently  
 10 with the desires of the principal as expressed in this appointment. I understand that this  
 11 document gives me authority over health care decisions for the principal only if the principal  
 12 becomes incapacitated. I understand that I must act in good faith in exercising my authority  
 13 under this power of attorney. I understand that the principal may revoke this power of attorney at  
 14 any time in any manner.

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

18 \_\_\_\_\_  
 19 (Signature of agent/date)

20 \_\_\_\_\_  
 21 (Signature of alternate agent/date)

22 PRINCIPAL'S STATEMENT

23 I have read a written explanation of the nature and effect of an appointment of a health care  
 24 agent that is attached to my health care directive.

25 Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_. \_\_\_\_\_  
 26 (Signature of Principal)