23.0121.01000

Sixty-eighth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2125

Introduced by

Senators Mathern, Erbele, Hogan

Representatives Dobervich, Kasper, Swiontek

A BILL for an Act to amend and reenact sections 23-06.5-06 and 23-06.5-17 of the North Dakota Century Code, relating to health care directive acceptance of appointment as agent.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 23-06.5-06 of the North Dakota Century Code is amended and reenacted as follows:

23-06.5-06. ~~Acceptance of appointment -~~ Withdrawal as agent.

~~To be effective, the agent must accept the appointment in writing.~~ Subject to the right of the agent to withdraw, the ~~acceptance~~health care directive creates authority for the agent to make health care decisions on behalf of the principal at such time as the principal becomes incapacitated. Until the principal becomes incapacitated, the agent may withdraw by giving notice to the principal. After the principal becomes incapacitated, the agent may withdraw by giving notice to the attending physician. The attending physician shall cause the withdrawal to be recorded in the principal's medical record.

SECTION 2. AMENDMENT. Section 23-06.5-17 of the North Dakota Century Code is amended and reenacted as follows:

23-06.5-17. Optional health care directive form.

The following is an optional form of a health care directive and is not a required form:

HEALTH CARE DIRECTIVE

I_____, understand this document allows me to do ONE OR ALL of the following:

PART I: Name another ~~person~~individual (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~~individual 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:

_____

_____

_____

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 with 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:

_____

_____

_____

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:

_____

_____

_____

My fears about my health care:

_____

_____

_____

My spiritual or religious beliefs and traditions:

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

(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:

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

In all circumstances, my health care providers 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:

_____

_____

_____

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

Who I would like to be my health care provider:

_____

_____

_____

Where I would like to live to receive health care:

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

Any other things:

_____

_____

_____

PART III: MAKING AN ANATOMICAL GIFT

(A) I WANT TO BE AN ORGAN DONOR

[ ] 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:_____

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

[ ] I do not want 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.

PART IV: MAKING THE DOCUMENT LEGAL

~~PRIOR~~EARLIER DESIGNATIONS REVOKED. I revoke any ~~prior~~earlier health care directive.

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS HEALTH CARE DIRECTIVE)

I sign my name to this Health Care Directive Form on_____ at

(date)

_____

(city)

_____

(state)

_____

(you sign here)

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

Option 1: Notary Public

State of _____

County of _____

In my presence on _____ (date), _____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the ~~person~~individual 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~~individual 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~~individual 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 Two)

_____

(Address)

~~ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY. 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. 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 health care provider.~~

~~_____~~

~~(Signature of agent/date)~~

~~_____~~

~~(Signature of alternate agent/date)~~

PRINCIPAL'S STATEMENT

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

Dated this _____ day of _____, 20 _____. _____

(Signature of Principal)