

INSTRUCTIONS

NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY

(Notice: This document gives the person you designate as 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 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.)

1. Designation of health care agent.

I, _____, being of sound mind,
(name)

hereby appoint _____
(name of health care agent)

(home address)

(home telephone number)

(work telephone number)

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.

PRINT YOUR NAME

**PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF YOUR
AGENT**

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PARTNERSHIP FOR CARING,
INC.

ALTERNATE AGENTS

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE AGENTS

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 first alternate health care agent)

(home address)

(home telephone number) (work telephone number)

B. _____
(name of second alternate health care agent)

(home address)

(home telephone number) (work telephone number)

Each successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent.

2. Effectiveness of appointment.

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:

NAME THE PHYSICIAN(S) WHO WILL DETERMINE WHEN YOU CAN NO LONGER MAKE MEDICAL DECISIONS (OPTIONAL)

NAME THE PHYSICIAN (S) OR ELIGIBLE PSYCHOLOGIST (S) WHO WILL DETERMINE WHEN YOU CAN NO LONGER MAKE MENTAL HEALTH TREATMENT DECISIONS

For decisions related to mental health treatment, this determination shall be made by the following physician or eligible psychologist:

3. General statement of authority granted.

Except as indicated in section 4 below, I hereby grant to my health care agent named above full power and authority to make health care decisions, including mental health treatments 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 and to 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.

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.

4. Special provisions and limitations.

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:

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.

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 that you lack sufficient understanding or capacity to make or communicate mental health treatment decisions. Because your health care agent's 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.

5. 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).

**LIST LIMITATIONS
ON YOUR AGENT'S
POWER
(IF ANY)**

6. 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.

7. 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.

8. 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.

_____ *signature of principal*

_____ *date*

9. Signatures of Witnesses.

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.

Witness: _____ Date: _____

Witness: _____ Date: _____

**SIGN AND DATE
YOUR DOCUMENT**

**WITNESSING
PROCEDURE**

**WITNESSES SIGN
AND DATE YOUR
DOCUMENT BELOW**

**A NOTARY PUBLIC
MUST COMPLETE
THIS SECTION OF
YOUR DOCUMENT**

STATE OF NORTH CAROLINA
COUNTY OF _____

CERTIFICATE

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_____.

Notary Public _____

My Commission Expires: _____

INSTRUCTIONS

NORTH CAROLINA DECLARATION OF A DESIRE FOR A NATURAL DEATH

PRINT YOUR NAME

I, _____,
(name)

being of sound mind, desire that, 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:

(Initial any of the following, as desired):

**INITIAL THE
INSTRUCTIONS
THAT REFLECT
YOUR WISHES**

_____ If my condition is determined to be terminal and incurable, I authorize the following:

___ My physician may withhold or discontinue extraordinary means only.

___ 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.

_____ If my physician determines that I am in a persistent vegetative state, I authorize the following:

___ My physician may withhold or discontinue extraordinary means only.

___ 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.

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

Other directions:

**SIGN AND DATE
THE DOCUMENT**

This the _____ day of _____, _____.
(day) (month) (year)

Signature _____

**WITNESSING
PROCEDURE**

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.

Witness _____

Witness _____

**WITNESSES SIGN
HERE**

CERTIFICATE

I, _____, Clerk (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 _____,
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 provided 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.

**A NOTARY PUBLIC,
CLERK OR
ASSISTANT CLERK
OF SUPERIOR
COURT MUST
COMPLETE THIS
SECTION**

This the _____ day of _____.

Notary Public of Clerk (Assistant Clerk) Superior Court

my commission expires: _____