

# NEW HAMPSHIRE MEDICAL POWER OF ATTORNEY

## 1. DISCLOSURE STATEMENT

### **THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING IT, YOU SHOULD KNOW THESE IMPORTANT FACTS:**

Except if you say otherwise in the directive, this directive gives the person you name as your health care agent the power to make any health care decisions for you when you cannot make health care decisions for yourself (in other words, you no longer have the ability to understand and appreciate generally the nature and consequences of a health care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care). "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your health care agent, therefore, will have the power to make a wide range of health care decisions for you. Your health care agent may consent (in other words, give permission), refuse to consent, or withdraw consent to medical treatment, and may make decisions about withdrawing or withholding life-sustaining treatment. Your health care agent cannot consent to or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy, unless the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this directive any treatment you do not want, or any treatment you want to be sure you receive. Your health care agent's power will begin when your doctor certifies that you cannot make health care decisions (in other words, that you are not able to make health care decisions). If for moral or religious reasons you do not want to be treated by a doctor or to be examined by a doctor to certify that you lack capacity, you must say so in the directive and you must name someone who can certify your lack of capacity. That person cannot be your health care agent or alternate health care agent or any person who is not eligible to be your health care agent. You may attach additional pages to the document if you need more space to complete your statement.

If you want to give your health care agent the power to withhold or withdraw medically administered nutrition and hydration, you must say so in your directive. Otherwise, your health care agent will not be able to direct that. Under no conditions will your health care agent be able to direct the withholding of food and drink that you are able to eat and drink normally.

Your agent shall be directed by your written instructions in this document when making decisions on your behalf, and as further guided by your medical condition or prognosis. Unless you state otherwise in the directive, your agent will have the same power to make decisions about your health care as you would have made, if those decisions by your health care agent are made consistent with state law.

You must discuss this directive with your doctor or other health care providers before you sign it, to make sure that you understand the nature and range of decisions that could be made for you by your

health care agent. If you do not have a health care provider, you should talk with someone else who is knowledgeable about these issues and can answer your questions. Check with your community hospital or hospice for trained staff. You do not need a lawyer's assistance to complete this directive, but if there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

The person you choose as your health care agent should be someone you know and trust, and he or she must be at least 18 years old. If you choose your health or residential care provider (such as your doctor, advanced practice registered nurse, or an employee of a hospital, nursing home, home health agency, or residential care home, other than a relative), that person will have to choose between acting as your health care agent or as your health or residential care provider, because the law does not allow a person to do both at the same time.

You should consider choosing an alternate health care agent, in case your health care agent is unwilling, unable, unavailable, or not eligible to act as your health care agent. Any alternate health care agent you choose will have the same authority to make health care decisions for you.

You should tell the person you choose that you want him or her to be your health care agent. You should talk about this directive with your health care agent and your doctor or advanced practice registered nurse and give each one a signed copy. You should write the people and institutions who will have signed copies on the directive itself. Your health care agent will not be liable for health care decisions made in good faith on your behalf.

**EVEN AFTER YOU HAVE SIGNED THIS DIRECTIVE, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AS LONG AS YOU CAN DO SO, AND TREATMENT CAN NOT BE GIVEN TO YOU OR STOPPED OVER YOUR CLEAR OBJECTION. You have the right to revoke the power given to your health care agent by telling him or her, or by telling your health care provider, orally or in writing, that you no longer want that person to be your health care agent.**

**YOU HAVE THE RIGHT TO EXCLUDE OR STRIKE REFERENCES TO APRN'S IN YOUR ADVANCE DIRECTIVE AND IF YOU DO SO, YOUR ADVANCE DIRECTIVE SHALL STILL BE VALID AND ENFORCEABLE.**

Once this directive is executed, it cannot be changed or modified. If you want to make changes, you must make an entirely new directive.

**THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR JUSTICE OF THE PEACE OR TWO (2) OR MORE QUALIFIED WITNESSES, WHO MUST BOTH BE PRESENT WHEN YOU SIGN AND WHO WILL ACKNOWLEDGE YOUR SIGNATURE ON THE DOCUMENT. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:**

- The person you have designated as your health care agent;
- Your spouse or heir at law;

\_\_\_\_ Your attending physician or APRN, or person acting under the direction or control of the attending physician or APRN;

ONLY ONE OF THE TWO WITNESSES MAY BE YOUR HEALTH OR RESIDENTIAL CARE PROVIDER OR ONE OF YOUR PROVIDER'S EMPLOYEES.

Name (Principal's Name): \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

## 2. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, \_\_\_\_\_, hereby appoint \_\_\_\_\_ of \_\_\_\_\_ as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document or as prohibited by law. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. I hereby appoint \_\_\_\_\_ of \_\_\_\_\_ as an alternate agent.

### 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 removing 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: cardiopulmonary resuscitation, 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 that 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 the power to act in those specific circumstances.

#### A. LIFE-SUSTAINING TREATMENT

1. If my state of health does not allow me to make healthcare decisions or if I become permanently incompetent, I authorize my agent to direct that life-sustaining treatment be discontinued.

YES

NO

2. In case I become permanently unconscious, I authorize my agent to direct that life-sustaining treatment be discontinued.

YES

NO

**B. MEDICALLY ADMINISTERED NUTRITION AND HYDRATION.**

3. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial feeding (artificial nutrition and hydration). In carrying out any instructions I have given above in #1 or #2 or any instructions I may write in #4 below, I authorize my agent to direct that:

Artificial nutrition and hydration are not to be started or, if started, be discontinued,

Although all other forms of life-sustaining treatment be withdrawn, artificial nutrition and hydration continue to be given to me.

(If you fail to complete item 3, your agent will not have the power to direct the withdrawal of artificial nutrition and hydration.)

**C. ADDITIONAL INSTRUCTIONS**

4. Here you may include any specific desires or limitations you deem appropriate, such as 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 unacceptable to you for any other reason. You may leave this question blank if you desire.

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(attach additional pages as necessary)

**3. DURATION**

I understand that this power of attorney exists indefinitely from the date I execute this document or until the established end date is reached. However, I may revoke the power of attorney at any moment by notifying my agent orally or in writing. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted to my agent continues to exist until I become able to make healthcare decisions for myself.

[This power of attorney ends on the following date: [MONTH] [DAY], [YEAR]].

**4. EXECUTION.**

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES NOT RELATED BY BLOOD OR MARRIAGE.

**5. VALIDITY.**

THIS MEDICAL POWER OF ATTORNEY IS NOT VALID UNLESS:

1. YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR
2. YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

**6. ORIGINAL AND COPIES OF THIS MEDICAL POWER OF ATTORNEY.**

The original of this document will be kept at \_\_\_\_\_ and the following persons and institutions will have signed copies:

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

In witness whereof, I have hereunto signed my name this \_\_\_\_\_ day of \_\_\_, 20 \_\_\_

\_\_\_\_\_  
Signature

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

I 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 has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness: \_\_\_\_\_ Address: \_\_\_\_\_

Witness: \_\_\_\_\_ Address: \_\_\_\_\_

**NOTARY ACKNOWLEDGMENT**

**STATE OF NEW HAMPSHIRE**

**COUNTY OF \_\_\_\_\_**

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_,  
by \_\_\_\_\_

\_\_\_\_\_

Notary Public/Justice of the Peace

My Commission Expires: