New Hampshire Living Will Declaration

RSA 137-H:3

Declaration made this_____ day of _____(month, year). 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 certified to be a terminal condition or a permanently unconscious condition by 2 physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized or that I will remain in a permanently unconscious condition and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary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 artificial nutrition and hydration. In carrying out any instruction I have given under this section, I authorize that artificial nutrition and hydration not be started or, if started, be discontinued. (yes) (no) (Circle your choice and initial beneath it. If you do not choose "yes," artificial nutrition and hydration will be provided and will not be removed.)

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physicians 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

State of _____

County_____

We, the following witnesses, being duly sworn each declare to the notary public or justice of the peace or other official signing below as follows:

1. The declarant signed the instrument as a free and voluntary act for the purposes expressed, or expressly directed another to sign for him.

2. Each witness signed at the request of the declarant, in his presence, and in the presence of the other witness.

3. To the best of my knowledge, at the time of the signing the declarant was at least 18 years of age, and was of sane mind and under no constraint or undue influence.

_____

Witness

_____

Witness

The affidavit shall be made before a notary public or justice of the peace or other official authorized to administer oaths in the place of execution, who shall not also serve as a witness, and who shall complete and sign a certificate in content and form substantially as follows:

Sworn to and signed before me by _____, declarant _____ and_____ , witnesses on_____.

_____

Signature

New Hampshire Statutory Form
Durable Power of Attorney for Healthcare

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

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTHCARE 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: 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 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.

1. If I become permanently incompetent to make healthcare decisions, and if I am also suffering from a terminal illness, I authorize my agent to direct that life-sustaining treatment be discontinued.
YES NO (Circle your choice and initial beneath it.)

2. Whether terminally ill or not, if I become permanently unconscious I authorize my agent to direct that life-sustaining treatment be discontinued.
YES NO (Circle your choice and initial beneath it.)

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 (circle your choice of (a) or (b) and initial beside it):

(a) artificial nutrition and hydration not be started or, if started, be discontinued,

—OR—

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

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.

(attach additional pages as necessary)

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my healthcare agent, I hereby appoint

_____
(name of alternate agent)
of _____
(address of alternate agent)
as alternate agent.

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. The original of this document will be kept at

_____

and the following persons and institutions will have signed copies: _____.

In witness whereof, I have hereunto signed my name this _____ day of _____, 20 _____.
(day) (month) (year)

_____
(signature)

I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for healthcare 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: _____

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: _____

HALT AN ORGANIZATION OF AMERICANS FOR LEGAL REFORM
Email: HALT@HALT.org http://www.HALT.org
Phone: 1-888-FOR-HALT (202) 887-8255
1612 K Street, NW Suite 510, Washington, DC 20006