South Dakota Living Will Declaration

S.D. Codified Laws § 34-12D-3

This is an important legal document. This document directs the medical treatment you are to receive in the event you are unable to participate in your own medical decisions and you are in a terminal condition. This document may state what kind of treatment you want or do not want to receive.
This document can control whether you live or die. Prepare this document carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will remain valid and in effect until and unless you revoke it. Review this document periodically to make sure it continues to reflect your wishes. You may amend or revoke this document at any time by notifying your physician and other health-care providers. You should give copies of this document to your physician and your family. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected and a notary public.

TO MY FAMILY, PHYSICIANS, AND ALL THOSE CONCERNED WITH MY CARE:

I, _____, willfully and voluntarily make this declaration as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my medical care.

With respect to any life-sustaining treatment, I direct the following:

(Initial only one of the following optional directives if you agree. If you do not agree with any of the following directives, space is provided below for you to write your own directives).

_____ **NO LIFE-SUSTAINING TREATMENT.** I direct that no life-sustaining treatment be provided. If life-sustaining treatment is begun, terminate it.

_____ **TREATMENT FOR RESTORATION.** Provide life- sustaining treatment only if and for so long as you believe treatment offers a reasonable possibility of restoring to me the ability to think and act for myself.

_____ **TREAT UNLESS PERMANENTLY UNCONSCIOUS.** If you believe that I am permanently unconscious and are satisfied that this condition is irreversible, then do not provide me with life-sustaining treatment, and if life-sustaining treatment is being provided to me, terminate it. If and so long as you believe that treatment has a reasonable possibility of restoring consciousness to me, then provide life-sustaining treatment.

_____ **MAXIMUM TREATMENT.** Preserve my life as long as possible, but do not provide treatment that is not in accordance with accepted medical standards as then in effect.

(Artificial nutrition and hydration is food and water provided by means of a nasogastric tube or tubes inserted into the stomach, intestines, or veins. If you do not wish to receive this form of treatment, you must initial the statement below which reads: “I intend to include this treatment, among the ‘life-sustaining treatment’ that may be withheld or withdrawn.”)

With respect to artificial nutrition and hydration, I wish to make clear that

(Initial only one)

_____ I intend to include this treatment among the “life-sustaining treatment” that may be withheld or withdrawn.

_____ I do not intend to include this treatment among the “life-sustaining treatment” that may be withheld or withdrawn.

(If you do not agree with any of the printed directives and want to write your own, or if you want to write directives in addition to the printed provisions, or if you want to express some of your other thoughts, you can do so here.)

Date: _____ _____(your signature)

_____(your address) _____(type or print your signature)

The declarant voluntarily signed this document in my presence.

Witness _____

Address _____

Witness _____

Address _____

On this the _____ day of _____, _____, the declarant,_____, and witnesses _____, and _____, personally appeared before the undersigned officer and signed the foregoing instrument in my presence. Dated this _____ day of _____, _____,

_____

Notary Public

My commission expires: _____

South Dakota Durable Power of Attorney for Healthcare

I, _____, of
(name of principal)

_____
(address)

herby appoint _____
(name of attorney-in-fact)

of _____
(address and telephone number of attorney-in-fact)

as my attorney-in-fact to consent to, to reject, or to withdraw consent for medical procedures, treatment or intervention.

2) In the event the person I appoint above is unable, unwilling or unavailable to act as my healthcare agent, I hereby appoint :
_____, of
(name of successor attorney-in-fact)

_____.
(address and telephone number of successor attorney-in-fact)

3) I have discussed my wishes with my attorney-in-fact and my successor attorney-in-fact, and authorize him/her to make all and any healthcare decisions for me, including decisions to withhold or withdraw any form of life support. I expressly authorize my agent (and successor agent) to make decisions for me regarding the withholding or withdrawal of artificial nutrition and hydration in all medical circumstances.

4) This power of attorney becomes effective when I can no longer make my own medical decisions, and is not affected by physical disability or mental incompetence. The determination of whether I can make my own medical decisions is to be made by my attorney-in-fact, or if he or she is unable, unwilling or unavailable to act, by my successor attorney-in-fact, unless the attending physician determines that I have decisional capacity.

I, _____,
the principal, sign my name to this instrument this _____ day of _____, 20_____, and being first
(date) *(month)* *(year)*
duly sworn, do hereby declare to the undersigned authority that I sign it willingly (or willingly direct another to sign for me), that I execute it as my free and voluntary act for the purposes therein expressed, and that I am eighteen years of age or older, of sound mind, and under no constraint or undue influence.

_____
(signature of principal)

NOTARY

The State of South Dakota
The County of _____

Subscribed, sworn to, and acknowledged before me by _____, the principal, this
_____ day of _____, 20 _____.

(Seal)

_____
(notary public)

OR

WITNESS STATEMENT

I declare that the person who signed or acknowledged this Durable Power of Attorney for Health Care is personally known to me, that he/she signed or acknowledged this durable power of attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

Witness #1:

Signature: _____ Date: _____

Print Name: _____ Telephone Number: _____

Residence Address: _____

_____

Witness #2:

Signature: _____ Date: _____

Print Name: _____ Telephone Number: _____

Residence Address: _____

_____

HALT

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