

***Declaration of a Desire for a Natural Death  
As Set Forth in the Right to a Natural Death Act***

I, \_\_\_\_\_, 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 physician(s) 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:)

\_\_\_\_\_ 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 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 are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

This the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

Signature \_\_\_\_\_

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 \_\_\_\_\_

The clerk or the assistant clerk, or a notary public may, upon proof, certify the declaration as follows:

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 provides 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.

This the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for the County of \_\_\_\_\_

Notary Public \_\_\_\_\_

My Commission Expires \_\_\_\_\_

# Health Care Power of Attorney

## 1. Designation of Health Care Agent

I, \_\_\_\_\_, being of sound mind, hereby appoint

Name \_\_\_\_\_

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.

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 \_\_\_\_\_

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

Home Telephone Number: \_\_\_\_\_

Work Telephone Number: \_\_\_\_\_

B. Name \_\_\_\_\_

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

(Notice: This health care power of attorney may be revoked by you at any time in any manner by which you are able to communicate your intent to revoke to your health care agent and your attending physician.)

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 (You may include here a designation of your choice, including your attending physician, or any other physician. You may also name two or more physicians, if desired, both of whom must make this determination before the authority granted to the health care agent becomes effective.):

## 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 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 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.
- E 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.***

- F 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.
- G To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medial providers.

## 4. Special Provisions and Limitations

(Notice: The above grant of power is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care. If you wish to limit the scope of your health care agent's powers, you may do so in this section.)

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 (Here you may include any specific limitations you deem appropriate such as: your own definition of when life-sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or unacceptable to you for any other reason.):

## 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 sever without bond or security.

**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 discharge 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. Signature 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: \_\_\_\_\_

STATE OF NORTH CAROLINA  
COUNTY OF \_\_\_\_\_ CERTIFICATE

I, \_\_\_\_\_  
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: \_\_\_\_\_

(A copy of this form should be given to your health care agent and any alternate named in this power of attorney, and to your physician and family members.)

I \_\_\_\_\_ agree to act as health care agent for \_\_\_\_\_ pursuant to this health care power of attorney.

This the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_