

ADVANCE DIRECTIVE FOR A
NATURAL DEATH ("LIVING WILL")

COUNTY OF _____

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS: You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until a notary public is present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: <http://www.secretary.state.nc.us/ahcdr/>

Expires July 31, 2020: In response to the COVID-19 state of emergency, the General Assembly passed S.L. 2020-3, which adds § 90-321.1., a new section that temporarily waives the requirement that two witnesses sign this health care directive; the temporary waiver expires July 31, 2020.

S.L. 2020-3, also adds § 10B-25., a new section that temporarily permits the use of video technology to notarize certain documents including this advance health care directive. This form incorporates both those changes.

My Desire for a Natural Death

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply *IF* my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES.

_____ (Initial)	I have an incurable or irreversible condition that will result in my death within a relatively short period of time.
_____ (Initial)	I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.
_____ (Initial)	I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

2. These are My Directives about Prolonging My Life:

In those situations I have initialed in Section 1, I direct that my health care providers:

NOTE: INITIAL ONLY IN ONE PLACE.

_____ (Initial)	may withhold or withdraw life-prolonging measures.
_____ (Initial)	shall withhold or withdraw life-prolonging measures.

3. Exceptions – "Artificial Nutrition or Hydration"

NOTE: INITIAL ONLY IF YOU WANT TO MAKE EXCEPTIONS TO YOUR INSTRUCTIONS IN PARAGRAPH 2.

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1:

_____ (Initial)	I <i>DO</i> want to receive BOTH artificial hydration AND artificial nutrition (for example, through tubes) in those situations. NOTE: DO NOT INITIAL THIS BLOCK IF ONE OF THE BLOCKS BELOW IS INITIALED.
_____ (Initial)	I <i>DO</i> want to receive ONLY artificial hydration (for example, through tubes) in those situations. NOTE: DO NOT INITIAL THE BLOCK ABOVE OR BELOW IF THIS BLOCK IS INITIALED.
_____ (Initial)	I <i>DO</i> want to receive ONLY artificial nutrition (for example, through tubes) in those situations. NOTE: DO NOT INITIAL EITHER OF THE TWO BLOCKS ABOVE IF THIS BLOCK IS INITIALED.

4. I Wish to be Made as Comfortable as Possible

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

5. I Understand my Advance Directive

I am aware and understand that this document directs certain life-prolonging measures to be withheld or discontinued in accordance with my advance instructions.

6. If I have an Available Health Care Agent

If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that:

_____ (Initial)	<u>Follow Advance Directive:</u> This Advance Directive will override instructions my health care agent gives about prolonging my life.
_____ (Initial)	<u>Follow Health Care Agent:</u> My health care agent has authority to override this Advance Directive.

NOTE: DO NOT INITIAL BOTH BLOCKS. IF YOU DO NOT INITIAL EITHER BOX, THEN YOUR HEALTH CARE PROVIDERS WILL FOLLOW THIS ADVANCE DIRECTIVE AND IGNORE THE INSTRUCTIONS OF YOUR HEALTH CARE AGENT ABOUT PROLONGING YOUR LIFE.

7. My Health Care Providers May Rely on this Directive

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

8. I Want this Directive to be Effective Anywhere

I intend that this Advance Directive be followed by any health care provider in any place.

9. I have the Right to Revoke this Advance Directive

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

This the _____ day of _____, _____.

_____ (Signature of Declarant)

_____ (Type/Print Name)

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by _____ (type/print name of declarant)

Date _____ (Official Seal) _____ (Signature of Notary Public)

_____, Notary Public (Printed or typed name)

My commission expires: _____

Session Law 2020-3 temporarily permits the use of video technology to notarize documents pursuant to N.C. Gen. Stat § 10B-25. If this document is being notarized using video technology, the notary is required to fill out the following:

I signed this notarial certificate on _____ according to the emergency video notarization requirements contained in G.S. 10B-25. Date

Notary Public location during video notarization: _____ County

Stated physical location of principal during video notarization: _____ County

NOTE: THIS DOCUMENT WAS EXECUTED IN ACCORDANCE WITH THE PROCEDURES OF N.C. GEN. STAT. § 90-321.1.