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 AND 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 *DO* 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 *DO* 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 *DO* 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)* Follow Advance Directive: This Advance Directive will **override** instructions my health care agent gives about prolonging my life.

_____ *(Initial)* Follow Health Care Agent: 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
Print Name _____

I hereby state that the declarant, _____, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not 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, nor a licensed health care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____COUNTY,

STATE OF NORTH CAROLINA

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

_____
(type/print name of witness)

_____
(type/print name of witness)

Date _____ _____
Signature of Notary Public

_____, Notary Public
(Official Seal) *Printed or typed name*

My commission expires: _____