NEW HAMPSHIRE ADVANCE DIRECTIVE

By statute, (RSA 137-J:20 Advance Directive) the NEW HAMPSHIRE ADVANCE DIRECTIVE consists of two sections: DURABLE POWER OF ATTORNEY FOR HEALTH CARE and LIVING WILL. We have elected to state each in a separate form. You may complete both forms, or only one form.

(Initial beside the forms you elect to complete.)

_____ I elect to complete (or have previously completed) a LIVING WILL form.

_____ I also elect to complete (or have previously completed) a DOCUMENT OF GIFT - ANATOMICAL GIFTS form pursuant to RSA 291-A the UNIFORM ANATOMICAL GIFT ACT.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, W. Michael Todd, hereby appoint **Ginni Walsh** of Law Office of W. Michael Todd, PLLC, P.O. Box 888, New London, NH 03257, (603) 526-9020 as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this directive or as prohibited by law. This durable power of attorney for health care shall take effect in the event I lack the capacity to make my own health care decisions.

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint **Brynne Johnstone** of Law Office of W. Michael Todd, PLLC, P.O. Box 888, New London, NH 03257, (603) 526-9020, as alternate agent(s), in the order named.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE 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: 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.

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A. LIFE-SUSTAINING TREATMENT.

1. If I am near death and lack the capacity to make health care decisions, I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

_____(a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____(b) life-sustaining treatment continue to be given to me.

2. Whether near death or not, if I become permanently unconscious I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

____(a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

____(b) life-sustaining treatment continue to be given to me.

B. MEDICALLY ADMINISTERED NUTRITION AND HYDRATION.

I realize that situations could arise in which the only way to allow me to die would be to not start or to discontinue medically administered nutrition and hydration. In carrying out any instructions I have given in this document, I authorize my agent to direct that:

(Initial beside your choice of 1 or 2.)

____1. Medically administered nutrition and hydration not be started or, if started, be discontinued.

-or-

____2. Even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

(If you fail to complete item B, your agent will not have the power to direct the withholding or withdrawal of medically administered nutrition and hydration.)

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C. ADDITIONAL INSTRUCTIONS.

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 are unacceptable to you for any other reason. You may leave this question blank if you desire.

*(Initial beside only those provisions you want to apply. If **not** initialed, the provision will have no effect.)*

_____**1. Personal Representative under HIPAA.** I have executed a separate Authorization for Release of Protected Health Information (Valid Authorization Under 45 CFR Chapter 164) naming the appropriate agents.

_____**2. Care Arrangements.** I authorize my health care agent to make any and all necessary arrangements for me at any hospital, hospice, nursing home, convalescent home or similar facility, and to assure that all of my essential medical, dental, mental health, physical therapy and other needs are provided for at any such facility, in accordance with any instructions I may have given in my estate plan.

_____**3. Authorized to Act Despite My Objection.** Even if I am incapacitated and I object to treatment, treatment may be given to me over my objection. It is my specific intent that my agent shall have full and complete authority to make decisions regarding my health care and treatment when I am incapacitated, even if I may object to any decision reached by my agent at that time. (See e.g. RSA 137-J: 5, IV.)

_____**4. Authorize Agent to Consent to DNR order.** I authorize my agent, in their sole and absolute discretion, to consent to a "do not resuscitate order" (DNR) on my behalf in accordance with RSA 137-J:26, III.

_____**5. Negate Authorization for ARNP to Act.** I desire to **exclude** any Advance registered nurse practitioner (ARNP) from having any powers granted in this document, as provided in RSA 137-J:14, III. Any reference to an ARNP in this document, if signed by me shall be deemed to be stricken and have no effect.

_____**6. Pain Medication.** I wish to be given pain medication which is necessary to control my pain without regard to any of the above choices and authorize my agent to approve the administration of such medication.

_____**7. Palliative Sedation.** In an end-of-life situation, I authorize my agent, in their sole and absolute discretion, to approve the administration of sedation to the point of my unconsciousness, where I am suffering from severe, unremitting

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symptoms (pain, delirium, agitation, dyspnea, seizures) that are untractable and unrelieved despite aggressive symptom-specific treatment.

_____**8. Broad Authority of Agent.** It is my intent to grant to my agent the broadest and most complete power and authority to act in making all health care decisions on my behalf, as I would have if I had capacity to do so, including all decisions to both consent and to withhold treatment, in addition to that specifically set forth in this Advance directive. In complying with this grant, no then existing statutory authority or other presumption in law shall in any way limit my agent's authority hereby granted. If any provisions of this Advance directive or its application to any person or circumstance is held invalid or otherwise deemed unenforceable by virtue of my desire to give my agent the broadest powers possible, it is my intention that such invalidity shall not in any way effect any other provisions or applications of this Advance directive, which can be given effect without the invalid provisions or applications.

D. SPECIFIC DESIRES OR LIMITATIONS

(Initial beside your choice of 1 or 2.)

_____1. I decline to include any specific desires or limitations other than those indicated above.

_____2. I elect to include specific desires or limitations, and include ____ pages signed and dated by me to be included herewith and incorporated by reference into this document.

_____

_____

_____

(Attach additional pages as necessary.)

I hereby acknowledge that I have been provided with a Disclosure Statement explaining the effect of this directive. I have read and understand the information contained in the disclosure statement.

The original of this directive will be kept at 159 Old Main Street, New London, NH, and the following persons and institutions will have signed copies:

Law Office of W. Michael Todd, PLLC, 159 Old Main Street, P.O. Box 888, New London, NH 03257-0888

My Healthcare Agents named in this document

Your Doctor's Name Here (if you prefer), Your Doctor's Office Address Here (if you prefer),

Docubank, P.O. Box 325, Narberth, PA 10972-0325

_____

Signed this 29th day of May, 2007

_____
W. Michael Todd, Principal

[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]

THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal, W. Michael Todd, appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that W. Michael Todd affirms that he is aware of the nature of the directive and is signing it freely and voluntarily.

_____ _____

Witness: _____ Witness: _____

Address: _____ Address: _____

_____ _____

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STATE OF NEW HAMPSHIRE

COUNTY OF MERRIMACK

The foregoing durable power of attorney for health care was acknowledged before me this 29th day of May, 2007, by W. Michael Todd ("the Principal") and Witness: _____ _____and Witness: _____ the witnesses.

_____
Notary Public
My commission expires: _____

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Disclosure Statement)

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING IT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except if you say otherwise in the directive, this directive gives the person you name as your health care agent the power to make any and all health care decisions for you when you lack the capacity to make health care decisions for yourself (in other words, you no longer have the ability to understand and appreciate generally the nature and consequences of a health care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care). "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition.

Your health care agent, therefore, will have the power to make a wide range of health care decisions for you. Your health care agent may consent (in other words, give

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permission), refuse to consent, or withdraw consent to medical treatment, and may make decisions about withdrawing or withholding life-sustaining treatment.

Your health care agent cannot consent to or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy, unless the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this directive any treatment you do not want, or any treatment you want to be sure you receive. Your health care agent's power will begin *when your doctor certifies that you lack the capacity to make health care decisions* (in other words, that you are not able to make health care decisions). If for moral or religious reasons you do not want to be treated by a doctor or to be examined by a doctor to certify that you lack capacity, *you must say so in the directive* and *you must name someone who can certify your lack of capacity*. That person cannot be your health care agent or alternate health care agent or any person who is not eligible to be your health care agent. You may attach *additional pages* to the document if you need more space to complete your statement.

If you want to give your health care agent power to withhold or withdraw medically administered nutrition and hydration, *you must say so* in your directive. Otherwise, your health care agent will not be able to direct that. Under no conditions will your health care agent be able to direct the withholding of food and drink that you are able to eat and drink normally.

Your agent shall be directed by your written instructions in this document when making decisions on your behalf, and as further guided by your medical condition or prognosis. *Unless you state otherwise* in the directive, your agent will have the *same* power to make decisions about your health care as you would have made, if those decisions by your health care agent are made consistent with state law.

It is important that you discuss this directive with your doctor or other health care providers before you sign it, to make sure that you understand the nature and range of decisions which could be made for you by your health care agent. If you do not have a health care provider, you should talk with someone else who is knowledgeable about these issues and can answer your questions. Check with your community hospital or hospice for trained staff. You do not need a lawyer's assistance to complete this directive, but if there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

The person you choose as your health care agent should be someone you know and trust, and he or she must be at least 18 years old. If you choose your health or residential care provider (such as your doctor, advanced registered nurse practitioner, or an employee of a hospital, nursing home, home health agency, or residential care home, other than a relative), that person will have to choose between acting as your health care

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agent or as your health or residential care provider, because the law does not allow a person to do both at the same time.

You should consider choosing an alternate health care agent, in case your health care agent is unwilling, unable, unavailable or not eligible to act as your health care agent. Any alternate health care agent you choose will then have the same authority to make health care decisions for you.

You should tell the person you choose that you want him or her to be your health care agent. You should talk about this directive with your health care agent and your doctor or advanced registered nurse practitioner and give each one a signed copy. You should write on the directive itself the people and institutions who will have signed copies. Your health care agent will not be liable for health care decisions made in good faith on your behalf.

EVEN AFTER YOU HAVE SIGNED THIS DIRECTIVE, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AS LONG AS YOU ARE ABLE TO DO SO, AND TREATMENT CANNOT BE GIVEN TO YOU OR STOPPED OVER YOUR CLEAR OBJECTION. You have the right to revoke the power given to your health care agent *by telling him or her*, or by *telling your health care provider*, orally or in writing, that you no longer want that person to be your health care agent.

Once this directive is executed it cannot be changed or modified. If you want to make changes, you must make an entirely new directive.

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF A NOTARY PUBLIC OR JUSTICE OF THE PEACE OR TWO (2) OR MORE QUALIFIED WITNESSES, WHO MUST BOTH BE PRESENT WHEN YOU SIGN AND WHO WILL ACKNOWLEDGE YOUR SIGNATURE ON THE DOCUMENT. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

- The person you have designated as your health care agent;
- Your spouse or heir at law;
- Your attending physician or ARNP, or person acting under the direction or control of the attending physician or ARNP;

ONLY ONE OF THE TWO WITNESSES MAY BE YOUR HEALTH OR RESIDENTIAL CARE PROVIDER OR ONE OF YOUR PROVIDER'S EMPLOYEES.

(End of Disclosure Statement)

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