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) the DURABLE POWER OF ATTORNEY FOR HEALTH CARE 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.

LIVING WILL

Declaration made this 29th day of May, 2007.

I, W. Michael Todd, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness and I am certified to be near death or in a permanently unconscious condition by:

(*Initial beside your choice of medical authority (a) or (b).*)

_____(a) 2 physicians; I desire to **exclude** any advanced 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; or

_____(b) a physician and an ARNP; or

and the medical authority I have indicated above has determined that:

my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or

that I will remain in a permanently unconscious condition,

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I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the natural ingestion of food or fluids by eating and drinking, or the performance of any medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue medically administered nutrition and hydration.

In carrying out any instruction I have given under this section, I authorize that:

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

____(a) medically administered nutrition and hydration not be started or, if started, be discontinued,

-or-

____(b) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and health care providers as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

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.*]

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THIS LIVING WILL 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 living will 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:
_____	_____
_____	_____

STATE OF NEW HAMPSHIRE

COUNTY OF MERRIMACK

The foregoing living will 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: March 23, 2010

(Disclosure Statement Follows)

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INFORMATION CONCERNING THE LIVING WILL

(Disclosure Statement)

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

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 it. 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.

You should talk about this directive with your health care agent and your doctor or advance registered nurse practitioner (ARNP) and give each one a signed copy. You should write on the directive itself the names of 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 EXCLUDE OR STRIKE REFERENCES TO ARNP'S IN YOUR ADVANCE DIRECTIVE AND IF YOU DO SO, YOUR ADVANCE DIRECTIVE SHALL STILL BE VALID AND ENFORCEABLE.

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

(End of Disclosure Statement)

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