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

STATE OF NORTH CAROLINA

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 witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are 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.nclifelinks.org/ahcdr/

My Desire for a Natural Death

I, (print name) __________________________, 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.

________ shall withhold or withdraw life-prolonging measures.

(Initial)

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

____
Type/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 healthcare 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

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 ____________________________
(Official Seal)

____
Signature of Notary Public

____, Notary Public
Printed or typed name

My commission expires: __________________

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HEALTH CARE POWER OF ATTORNEY

STATE OF NORTH CAROLINA

COUNTY OF ________________

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

EXPLANATION: *You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.*

This document gives the person you designate as your health care agent broad powers to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney 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 witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. ***Do not sign this form until*** *two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.nclifelinks.org/ahcdr/*

1. Designation of Health Care Agent.

I, (print name) ____________________________, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) 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. My designated health care agent(s) shall serve alone, in the order named.

A. Name: ________________________________ Home Telephone: ___________________________

Home Address: ___________________________ Work Telephone: ___________________________

____ Cellular Telephone: _________________________

B. Name: ________________________________ Home Telephone: ___________________________

Home Address: ___________________________ Work Telephone: ___________________________

____ Cellular Telephone: _________________________

C. Name: ________________________________ Home Telephone: ___________________________

Home Address: ___________________________ Work Telephone: ___________________________

____ Cellular Telephone: _________________________

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of Appointment.

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. ____________________________________ *(Physician)*

2. ____________________________________ *(Physician)*

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

3. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

4. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving 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. Employing or discharging my health care providers.

C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.

E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."

F. Giving consent for, withdrawing consent for, or withholding 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, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorizing the withholding or withdrawal of life-prolonging measures.

H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take

any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.

I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. Special Provisions and Limitations.

(Notice: The authority granted in this document 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 treatment or service. If you wish to limit the scope of your health care agent's powers, you may do so in this section. If none of the following are initialed, there will be no special limitations on your agent's authority.)

A. Limitations about Artificial Nutrition or Hydration: In exercising the authority to make health care decisions on my behalf, my health care agent:

________ Shall NOT have the authority to withhold artificial nutrition (such as through tubes) OR may
(Initial) exercise that authority only in accordance with the following special provisions:

____

________ Shall NOT have the authority to withhold artificial hydration (such as through tubes) OR
(Initial) may exercise that authority only in accordance with the following special provisions:

____

NOTE: If you initial either block but do not insert any special provisions, your health care agent shall have NO AUTHORITY to withhold artificial nutrition or hydration.

B. Limitations Concerning Health Care Decisions.

________ In exercising the authority to make health care decisions on my behalf, the authority of my
(Initial) health care agent is subject to the following provisions: (Here you may include any specific you deem appropriate such as: your own definition when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)

____

____

NOTE: DO NOT initial unless you insert a limitation.

C. Limitations Concerning Mental Health Decisions.

________ In exercising the authority to make mental health decisions on behalf, the authority of my
(Initial) health care agent is subject to following special provisions: (Here you may include any provisions you deem appropriate such as: limiting grant of authority to make only mental health treatment, your own instructions regarding the administration withholding of psychotropic medications and treatment (ECT), regarding admission to and retention in a health care facility for health treatment, or instructions to refuse any specific of treatment that are unacceptable to you.) ________________________________

____

NOTE: DO NOT initial unless you insert a limitation.

D. Advance Instruction for Mental Health Treatment.

________ (Initial) (Notice: This health care power of attorney may incorporate or be with an advance instruction for mental health, executed in accordance with Part 2 of Article 3 of 122C of the General Statutes, which you may use to your instructions regarding mental health treatment in event you lack capacity to make or communicate mental treatment decisions. Because your health care agent's must be consistent with any statements you have in an advance instruction, you should indicate here you have executed an advance instruction for mental treatment): ____

____

NOTE: DO NOT initial unless you insert a limitation.

E. Autopsy and Disposition of Remains.

________ (Initial) In exercising the authority to make decisions regarding autopsy and disposition of remains 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 such as: limiting the grant of authority and the of authority, or instructions regarding burial or cremation): ____

____

NOTE: DO NOT initial unless you insert a limitation.

6. Organ Donation.

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

________ (Initial) donate any needed organs or parts; or

________ (Initial) donate only the following organs or parts:

____

NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.

________ (Initial) donate my body for anatomical study if needed.

________ (Initial) In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations: (Here you may include any specific limitations deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of body or body parts.)

____

____

NOTE: DO NOT initial unless you insert a limitation.

NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.

7. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

8. 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 in reliance on that authority or those representations.

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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 action taken 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.

9. Miscellaneous Provisions.

A. Revocation of Prior Powers of Attorney. I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

B. Jurisdiction, Severability, and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, 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, entity, 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.

E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

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.

This the _____ day of ______________, 20____.

____(SEAL)

I hereby state that the principal, _______________________, being of sound mind, signed (or directed another to sign on the principal's behalf) 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 a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: ______________________________ Witness: ____

Date: ______________________________ Witness: ____

_______________COUNTY, ________________STATE

Sworn to (or affirmed) and subscribed before me this day by

____
(type/print name of signer)

____
(type/print name of witness)

____
(type/print name of witness)

Date: __________________________ ____
(Official Seal) *Signature of Notary Public*

______________________________________, Notary Public
Printed or typed name

My commission expires: _____________________________

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ADVANCE INSTRUCTION FOR MENTAL HEALTH TREATMENT

STATE OF NORTH CAROLINA

COUNTY OF ________________

(NOTICE TO PERSON MAKING AN INSTRUCTION FOR MENTAL HEALTH TREATMENT
This is an important legal document. It creates an instruction for mental health treatment.
Before signing this document you should know these important facts:
This document allows you to make decisions in advance about certain types of mental health treatment. The instructions you include in this declaration will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment law. Under the Health Care Power of Attorney you may also appoint a person as your health care agent to make treatment decisions for you if you become incapable. You have the right to revoke this document at any time you have not been determined to be incapable.
YOU MAY NOT REVOKE THIS ADVANCE INSTRUCTION WHEN YOU ARE FOUND INCAPABLE BY A PHYSICIAN OR OTHER AUTHORIZED MENTAL HEALTH TREATMENT PROVIDER. A revocation is effective when it is communicated to your attending physician or other provider. The physician or other provider shall note the revocation in your medical record. To be valid, this advance instruction must be signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.

NOTICE TO PHYSICIAN OR OTHER MENTAL HEALTH TREATMENT PROVIDER
Under North Carolina law, a person may use this advance instruction to provide consent for future mental health treatment if the person later becomes incapable of making those decisions. Under the Health Care Power of Attorney the person may also appoint a health care agent to make mental health treatment decisions for the person when incapable. A person is "incapable" when in the opinion of a physician or eligible psychologist the person currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions. This document becomes effective upon its proper execution and remains valid unless revoked. Upon being presented with this advance instruction, the physician or other provider must make it a part of the person's medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the advance instruction when the person is determined to be incapable, unless compliance is not consistent with G.S. 122C- 74(g). The physician or other mental health treatment provider shall promptly notify the principal and, if applicable, the health care agent, and document noncompliance with any part of an advance instruction in the principal's medical record. The physician or other mental health treatment provider may rely upon the authority of a signed, witnessed, dated and notarized advance instruction, as provided in G.S. 122C-75.)

I, (print name), being an adult of sound mind, willfully and voluntarily make this advance instruction for mental health treatment to be followed it if is determined by a physician or eligible psychologist that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means the process of providing for the physical, emotional, psychological, and social needs of the principal. "Mental health treatment includes electroconvulsive treatment (ECT), commonly referred to as "shock treatment", treatment of mental illness with psychotropic medication, and admission to and retention in a facility for care or treatment of mental illness.

I understand that under G.S. 122C-57, other than for specific exceptions stated there, mental health treatment may not be administered without my express and informed written consent or, if I am incapable of giving my informed consent, the express and informed consent of my legally responsible person, my health care agent named pursuant to a valid health care power of attorney, or my consent expressed in this advance instruction for mental health treatment. I understand that I may become incapable of giving or withholding informed consent for mental treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

____

____

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding psychoactive medications are as follows: *(Place initials beside choice.)*

______ I consent to the administration of the following medications:
____

______ I do not consent to the administration of the following medications:
____

Conditions or limitations: ____
____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding admission to and retention in a health care facility for mental health treatment are as follows: (Place initials beside choice.)

_____ I consent to being admitted to a health care facility for mental healthtreatment. My facility preference is
____

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This advance instruction cannot, by law, provide consent to retain me in a facility for more than ten (10) days.

Conditions or limitations: ____
____

ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity. In case of mental health crisis, please contact:

1. Name: ____
   Home Address: ____
   Home Telephone Number: ____
   Work Telephone Number: ____
   Relationship to Me: ____
2. Name: ____
   Home Address: ____
   Home Telephone Number: ____
   Work Telephone Number: ____
   Relationship to Me: ____
3. My Physician:
   Name: ____
   Telephone Number: ____
4. My Therapist:
   Name: ____
   Telephone Number: ____

The following may cause me to experience a mental health crisis:

____

The following help me avoid a hospitalization:

____

I generally react to being hospitalized as follows:

____

Staff of the hospital or crisis unit can help me by doing the following:

____

I give permission for the following person or people to visit me:

____

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as “shock treatment:

____

Other instructions:

____

____

_____ *(Initial if applicable)* I have attached an additional sheet of instructions to be followed and considered part of this advance instruction.

SHARING OF INFORMATION BY PROVIDERS

I understand that the information in this document may be shared by my mental health treatment provider with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction. Other instructions about sharing of information:

____

____

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 impact of having made this advance instruction for mental health treatment.

______________________________	______________________________
Date	Signature of Principal

NATURE OF WITNESSES

I hereby state that the principal is personally known to me, that the principal signed or acknowledged the principal’s signature on this advance instruction for mental health treatment in my presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that I am not:

a. The attending physician or mental health service provider or an employee of the physician or mental health treatment provider;

b. An owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident; or

c. Related within the third degree to the principal or to the principal’s spouse.

AFFIRMATION OF WITNESS

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is:

a. A person appointed as an attorney-in-fact by this document;

b. The principal's attending physician or mental health service provider or a relative of the physician or provider;

c. The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or

d. A person related to the principal by blood, marriage or adoption.

Witnessed by:

______________________________	______________________________
Witness	Witness
________________	________________
Date	Date

STATE OF NORTH CAROLINA

COUNTY OF ______________

CERTIFICATION OF NOTARY PUBLIC

I, ______________________________ , a Notary Public for the County cited

above in the State of North Carolina, hereby certify that ______________________________ appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance instruction for mental health treatment, 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 or affirmed that they witnessed ______________________________ sign the attached advance instruction for mental health treatment, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing they were not (i) the attending physician or mental health treatment provider or an employee of the physician or mental health treatment provider and (ii) they were not an owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident, and (iii) they were not related within the third degree to the principal or to the principal's spouse. 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: ______________