SOUTH DAKOTA LIVING WILL DECLARATION

This is an important legal document. A living will directs the medical treatment you are to receive in the event you are in a terminal condition and are unable to participate in your own medical decisions. This living will may state what kind of treatment you want or do not want to receive.

Prepare this living will carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This living will remains valid and in effect until and unless you revoke it. Review this living will periodically to make sure it continues to reflect your wishes. You may amend or revoke this living will at any time by notifying your physician and other health care providers. You should give copies of this living will to your family , your physician, and your health care facility. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected, and a notary public.

TO MY FAMILY, HEALTH CARE PROVIDER, AND ALL THOSE CONCERNED WITH MY CARE:

I, _____ direct you to follow my wishes for care if I am in a terminal condition, my death is imminent, and I am unable to communicate my decisions about my medical care.

With respect to any life-sustaining treatment, I direct the following:

(Initial only one of the following options. If you do not agree with either of the following options, space is provided below for you to write your own instructions.)

_____ If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

_____ Even if my death is imminent or I am permanently unconscious, I choose to prolong my life.

_____ I choose neither of the above options, and here are my instructions should I become terminally ill and my death is imminent or I am permanently unconscious:

_____
_____
_____
_____
_____
_____
_____

Artificial Nutrition and Hydration: food and water provided by means of a tube inserted into the stomach or intestine or needle into a vein.

With respect to artificial nutrition and hydration, I direct the following:

(Initial only one)

_____ If my death is imminent or I am permanently unconscious, I do not want artificial nutrition and hydration. If it has been started, stop it.

_____ Even if my death is imminent or I am permanently unconscious, I want artificial nutrition and hydration.

Date: _____

_____
(Your signature)

_____
(Type or print your signature)

_____
(Your address)

The declarant voluntarily signed this document in my presence.

Witness _____
(Signature)

_____
(Type or print signature)

Address _____
(Street) (City) (State)

Witness _____
(Signature)

_____
(Type or print signature)

Address _____
(Street) (City) (State)

On this the _____ day of _____, _____, the declarant, _____, and witnesses _____, and _____ personally appeared before the undersigned officer and signed the foregoing instrument in my presence.

Dated this _____ day of _____, 20_____.

_____
Notary Public

My commission expires: _____

{Seal}

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.

South Dakota Health Care Power of Attorney

This is an important legal document. This document designates the person you want to make medical decisions for you in the event you are unable to participate in your own medical decisions.

Fill out this document carefully. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will be in effect until you revoke it. Read this document from time to time to make sure it still reflects your wishes. You may change or revoke this document at any time by telling your doctor and other healthcare providers. You should give copies of this document to your doctor and family. This form is optional. If you choose to use this form, the form has signature lines for you and either two witnesses, or a notary.

1. Designation of Health Care Agent:

I, _____ hereby appoint: _____
(*Agent's name)*

Agent's Address _____

Agent's Home phone_____ Work Phone_____

As my attorney-in-fact (or "Agent") to make health and personal care decisions for me as authorized in this document.

Effective Date and Durability

By this document I intend to create a durable power of attorney effective upon, and only during, any period of incapacity that, in the opinion of my Agent and attending doctor, I am not able to make or communicate a choice regarding a particular health-care decision.

2. Agent's Powers

I grant to my Agent full authority to make decisions for me about my health care. In exercising this authority, my Agent will consider the recommendation of the attending doctor, the decision I would make if I had decisional capacity, if known, and the decision that would be in my best interest. I want my Agent to follow my desires as I have state in Section 3.

Accordingly, unless specifically limited by Section 3, below, my Agent is authorized as follows:

A. To consent, refuse or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

B. To have access to medical records and information to the same extent that I am entitled, including the right to disclose the contents to others;

C. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service;

D. To contact on my behalf for any health care related service or facility on my behalf, without my Agent incurring personal financial liability for such contracts;

E. To hire and fire medical, social service and other support personnel responsible for my care;

F. To authorize, or refuse to authorize, any medicine or procedure intended to relieve pain, even though such use may lead to physical damage, addiction , or hasten the moment of (but not intentionally cause) my death;

G. To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law;

H. To take any other action needed to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, doctor, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to week actual or punitive damages for the failure to comply.

3. Statement of Desires, Special Instructions, and Limitations

A. The powers granted above do not include the following powers or are subject to the following rules orlimitations.

_____

_____

_____

B. With respect to any Life-Sustaining Treatment, I direct the following: (*initial only one of the following paragraphs)*

_____ **Reference To Living Will.** I specifically direct my Agent to follow any health care declaration or "living will" executed by me.

_____ **Grant of Discretion To Agent.** I do not want my life to prolonged nor do I want life-sustaining treatment if my Agent believes the burdens of the treatment outweigh the expected benefits. I want my Agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

_____ **Directive To Withhold or Withdraw Treatment.** I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. If I have a condition that is incurable or irreversible and, without the administration of life-sustaining treatment, expected to result in imminent death;

OR

b. If I am in a coma or persistent vegetative state which is reasonably concluded to be irreversible.

_____ **Directive For Maximum Treatment.** I want my life to be prolonged to the greatest extent possible without regard to my condition, the changes I have for recovery, or the cost the procedures.

_____ **Directive In My Own Words.**

_____

_____

_____

C. With respect to nutrition and hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that . . . (initial only one)

_____**I want** these life sustaining procedures. However, I give my agent herein the express authority to later determine to discontinue these procedures should it be n my best interests to do so.

_____**I do NOT want** these life sustaining procedures under the conditions given above.

A. Alternate Agents

_____

First Alternate Agent

_____

Address

Telephone_____

B.

_____

Second Alternate Agent

_____

Address

Telephone_____

5. Protection of Third Parties Who Rely On My Agent
No person who relies in good faith upon any representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

6. Nomination of Guardian
If a guardian of my person should for any reason be appointed, I nominate my Agent (or his or her successor), named above.

7. Administrative Provisions
A. I revoke any prior power of attorney for health care.
B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.
C. My Agent shall not be entitled to compensation for services performed under this power of attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.

D. The powers delegated under this power of attorney are seperable, so that the invalidity jof one or more powers Shall not affect any jothers. By signing here I indicate that I understand the cjontenets jof this document and the effect of this grant of powers to my Agent.

I sign my name to this Health Care Power Of Attorney on this _____ day of _____, 20_____.

My current address is _____

My birth date is _____

_____
Signature

_____
Print Name

Witness Statement

I declare that the person who signed this document is personaly known to me, that he/she signed this durable power of attorney in my presence and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as agent in this document, nor am I the patient's health care provider, or an employee of the patient's health care provider. I further declare that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditorof the principal nor entitled to any part his.her estate under a will now existing or by operation of law.

_____ _____
Witness Witness

_____ _____
Address Address

OR

Notorization

State Of _____ County of _____

On this the _____ day of _____, 20_____,
The said _____, known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public, within and for the state and county aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

Notary Public _____

My Commission Expires_____

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