

State of South Dakota

EIGHTY-EIGHTH SESSION
LEGISLATIVE ASSEMBLY, 2013

634U0518

HOUSE BILL NO. 1192

Introduced by: Representatives Johns, Duvall, Feinstein, Hoffman, Lust, Rounds, Russell,
and Stevens and Senators Hunhoff (Jean), Lucas, and Tieszen

1 FOR AN ACT ENTITLED, An Act to provide a durable power of attorney form for health care
2 decisions.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

4 Section 1. A durable power of attorney for health care directive pursuant to § 59-7-2.5 may
5 be in the following form.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

7 I, _____, being an adult of sound mind, hereby appoint

8 (name of principal)

9 _____, of _____

10 (Name of agent) (his/her address and telephone number)

11 as my attorney-in-fact (agent) to consent to, to reject, or to withdraw consent for medical
12 procedures, treatment, or intervention. In the event the person I appoint above is unable,
13 unwilling, or unavailable to act as my health care agent, I appoint as my successor agent:

14 _____, of _____

15 (name of successor agent) (his/her address and telephone number)



1 My agent (or any successor agent) may make any health care decision for me which I could
 2 make individually if I had decisional capacity (except for any limitations given below). Any
 3 such decision shall be made in accordance with accepted medical standards and my agent (or
 4 any successor agent) may not authorize the withholding or withdrawal of comfort care from me.

5 My agent (or any successor agent) may authorize the withholding of life-sustaining treatment
 6 as set forth in my living will or advance directive (except for any limitations given therein) if
 7 I have executed one.

8 In the event I am unable to communicate verbally or nonverbally, demonstrate no purposeful
 9 movement or motor ability, and am unable to interact purposefully with environmental
 10 stimulation and (1) I have an incurable and irreversible condition such that, in accordance with
 11 accepted medical standards, death is imminent if life-sustaining treatment is not administered,
 12 or (2) I am in a coma or I have a condition of permanent unconsciousness that, in accordance
 13 with accepted medical standards, will last indefinitely without significant improvement: *(Initial*
 14 *only one of the following three options and if you do not agree with either of the first two*
 15 *options, space is provided below for you to write your own instructions.)*

16 _____ I authorize my agent (or any successor agent) to direct the withholding of artificial
 17 nutrition or hydration from me.

18 _____ I do not authorize my agent (or any successor agent) to direct the withholding of
 19 artificial nutrition or hydration from me.

20 _____ I authorize the following:_____.

21 This durable power of attorney for health care is effective only during a period in which my
 22 physician has determined in good faith that I do not have decisional capacity.

23 Whenever making any health care decision for me, my agent (or any successor agent) shall
 24 consider the recommendation of my attending physician, the decision I would have made if I

1 then had decisional capacity (if known) and the decision that would be in my best interests.

2 I give the following instructions to help guide my agent (or any successor agent): *(You may*
3 *write additional instructions or limitations below.)*

4 _____
5 _____
6 _____

7 Date: _____, 2 _____

8 _____
9 _____

(your signature)

10 (your address) _____ (type or print your name), principal

11 **Notarization**

12 On this the _____ day of _____, 2 _____, the principal, _____,
13 personally appeared before the undersigned officer and signed the foregoing document in my
14 presence.

15 _____
16 Notary Public

17 [SEAL]

18 My commission expires:

19 **OR**

20 **Statements of Two Witnesses**

21 The principal voluntarily signed this document in my presence.

22 _____
23 (first witness signature)

24 _____

1 (witness address) (type or print witness' name), witness

2 The principal voluntarily signed this document in my presence.

3 _____

4 (second witness signature)

5 _____

6 (witness address) (type or print witness' name), witness

7 **NOTICE TO PERSON MAKING A DURABLE POWER OF ATTORNEY**

8 **FOR HEALTH CARE**

9 This is an important legal document. Prepare this durable power of attorney for health care
10 carefully. If you use this form, read it completely. You may want to seek professional help to
11 make sure the form does what you intend and is completed without mistakes.

12 You have the right to revoke this document in whole or in part at any time you have not been
13 determined to be incapable. A revocation is effective when it is communicated to your attending
14 physician or other health care provider.