

operating subsidy for a hospital district created under sections 6 to 20, and any other hospital in the county notwithstanding Minnesota Statutes, sections 376.08 and 376.09 or any other limiting statutes or laws otherwise applicable to the county. The county may also guarantee any indebtedness incurred by or on behalf of the hospital and pledge its full faith and credit in support of it.

**Sec. 19. CITY OF BENSON.**

The city of Benson may make appropriations in whatever amount it deems appropriate for the purposes of capital acquisition, capital improvements, maintenance, and operating subsidy for a hospital district created under sections 6 to 20, notwithstanding any limiting statutes or laws otherwise applicable to the city. The city may also guarantee any indebtedness incurred by or on behalf of the hospital and pledge its full faith and credit in support of it.

**Sec. 20. POWERS SUPPLEMENTARY.**

The powers granted in sections 6 to 20 are supplementary to and not in substitution for any other powers possessed by political subdivisions in connection with the acquisition, betterment, administration, operation, and maintenance of hospitals, nursing homes, and related facilities and programs or the creation of hospital districts.

**Sec. 21. EFFECTIVE DATE.**

Sections 1 to 5 are effective the day after compliance with Minnesota Statutes, section 645.021, subdivision 3, by the governing body of the Yellow Medicine county hospital district.

Sections 6 to 20 are effective upon approval by majority of the county board of the county of Swift and by a majority of the city council of the city of Benson and upon compliance with all other provisions of Minnesota Statutes, section 645.021.

Presented to the governor April 17, 1992

Signed by the governor April 27, 1992, 1:54 p.m.

**CHAPTER 535—S.F.No. 2111**

*An act relating to living wills; adding certain information to the suggested health care declaration form; amending Minnesota Statutes 1990, section 145B.04.*

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1990, section 145B.04, is amended to read:

New language is indicated by underline, deletions by ~~strikeout~~.

**145B.04 SUGGESTED FORM.**

A declaration executed after August 1, 1989, under this chapter must be substantially in the form in this section. Forms printed for public distribution must be substantially in the form in this section.

**"Health Care Declaration****Notice:**

This is an important legal document. Before signing this document, you should know these important facts:

(a) This document gives your health care providers or your designated proxy the power and guidance to make health care decisions according to your wishes when you are in a terminal condition and cannot do so. This document may include what kind of treatment you want or do not want and under what circumstances you want these decisions to be made. You may state where you want or do not want to receive any treatment.

(b) If you name a proxy in this document and that person agrees to serve as your proxy, that person has a duty to act consistently with your wishes. If the proxy does not know your wishes, the proxy has the duty to act in your best interests. If you do not name a proxy, your health care providers have a duty to act consistently with your instructions or tell you that they are unwilling to do so.

(c) This document will remain valid and in effect until and unless you amend or revoke it. Review this document periodically to make sure it continues to reflect your preferences. You may amend or revoke the declaration at any time by notifying your health care providers.

(d) Your named proxy has the same right as you have to examine your medical records and to consent to their disclosure for purposes related to your health care or insurance unless you limit this right in this document.

(e) If there is anything in this document that you do not understand, you should ask for professional help to have it explained to you.

**TO MY FAMILY, DOCTORS, AND ALL THOSE CONCERNED WITH MY CARE:**

I, ....., born on ..... (birthdate), being an adult of sound mind, willfully and voluntarily make this statement as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my health care. I understand that my health care providers are legally bound to act consistently with my wishes, within the limits of reasonable medical practice and other applicable law. I also understand that I have the right to make medical and health care decisions for myself as long as I am able to do so and to revoke this declaration at any time.

New language is indicated by underline, deletions by ~~strikeout~~.

(1) The following are my feelings and wishes regarding my health care (you may state the circumstances under which this declaration applies):.....  
 .....  
 .....

(2) I particularly want to have all appropriate health care that will help in the following ways (you may give instructions for care you do want): .....  
 .....  
 .....

(3) I particularly do not want the following (you may list specific treatment you do not want in certain circumstances): .....  
 .....  
 .....

(4) I particularly want to have the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do want if you have a terminal condition): .....  
 .....  
 .....

(5) I particularly do not want the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do not want if you have a terminal condition): .....  
 .....  
 .....

(6) I recognize that if I reject artificially administered sustenance, then I may die of dehydration or malnutrition rather than from my illness or injury. The following are my feelings and wishes regarding artificially administered sustenance should I have a terminal condition (you may indicate whether you wish to receive food and fluids given to you in some other way than by mouth if you have a terminal condition): .....  
 .....  
 .....

(7) Thoughts I feel are relevant to my instructions. (You may, but need not, give your religious beliefs, philosophy, or other personal values that you feel are important. You may also state preferences concerning the location of your care.) .....  
 .....  
 .....

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(8) Proxy Designation. (If you wish, you may name someone to see that your wishes are carried out, but you do not have to do this. You may also name a proxy without including specific instructions regarding your care. If you name a proxy, you should discuss your wishes with that person.)

If I become unable to communicate my instructions, I designate the following person(s) to act on my behalf consistently with my instructions, if any, as stated in this document. Unless I write instructions that limit my proxy's authority, my proxy has full power and authority to make health care decisions for me. If a guardian or conservator of the person is to be appointed for me, I nominate my proxy named in this document to act as guardian or conservator of my person.

Name: .....

Address: .....

Phone Number: .....

Relationship: (If any) .....

If the person I have named above refuses or is unable or unavailable to act on my behalf, or if I revoke that person's authority to act as my proxy, I authorize the following person to do so:

Name: .....

Address: .....

Phone Number: .....

Relationship: (If any) .....

I understand that I have the right to revoke the appointment of the persons named above to act on my behalf at any time by communicating that decision to the proxy or my health care provider.

I (have) (have not) agreed in another document or on another form to donate some or all of my organs when I die.

DATE: .....

SIGNED: .....

STATE OF .....

.....

COUNTY OF .....

Subscribed, sworn to, and acknowledged before me by ..... on this .... day of ....., 19...

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.....  
NOTARY PUBLIC

OR

(Sign and date here in the presence of two adult witnesses, neither of whom is entitled to any part of your estate under a will or by operation of law, and neither of whom is your proxy.)

I certify that the declarant voluntarily signed this declaration in my presence and that the declarant is personally known to me. I am not named as a proxy by the declaration, and to the best of my knowledge, I am not entitled to any part of the estate of the declarant under a will or by operation of law.

Witness ..... Address .....

Witness ..... Address .....

Reminder: Keep the signed original with your personal papers.

Give signed copies to your doctors, family, and proxy."

Sec. 2. APPLICATION.

Section 1 does not affect the validity of a declaration that does not contain the provisions of section 1, if the declaration is otherwise substantially in the form in Minnesota Statutes, section 145B.04.

Presented to the governor April 17, 1992

Signed by the governor April 24, 1992, 4:10 p.m.

CHAPTER 536—S.F.No. 2499

*An act relating to economic development; authorizing the establishment of the Mille Lacs preservation and development board; proposing coding for new law in Minnesota Statutes, chapter 103F.*

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [103F.806] APPLICATION.

Sections 1 to 6 apply to the area of the counties of Mille Lacs, Crow Wing, and Aitkin located within one mile of Mille Lacs Lake. Sections 1 to 6 do not alter or expand the zoning jurisdiction of the counties within the exterior boundaries of the Mille Lacs Indian reservation.

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