

# Living Will Declaration

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_ (Month, Year).

I, \_\_\_\_\_, 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 certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal. I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

My additional instructions, if any, are listed on the reverse side.

Signed \_\_\_\_\_ (Declarant)

City, County and State of Residence \_\_\_\_\_

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am 18 or older, not related to the declarant by blood or marriage, not entitled to any portion of the estate of the declarant according to the laws of in testate succession or under any will of the declarant or codicil thereto, and not directly financially responsible for declarant's medical care.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

(OR) STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_

This instrument was acknowledged before me on \_\_\_\_\_ by \_\_\_\_\_ (Seal, if any)

\_\_\_\_\_  
(Signature of Notary Public) My appointment

expires \_\_\_\_\_

This declaration and optional additional instructions may be revoked or changed by declarant at any time.

Optional Additional Instructions

I make these optional additional instructions to my living will to exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions when I lack the capacity to make or communicate my decisions. If there is a phrase, statement or section below with which you do not agree, draw a line through it with your initials. I direct all life-prolonging procedures be withheld or withdrawn when there is no hope of significant recovery, and I have: · a terminal condition; or a condition, disease or injury without hope of significant recovery and there is no reasonable expectation that I will regain an acceptable quality of life; or · substantial brain damage or brain disease which cannot be significantly reversed; or other \_\_\_\_\_

I choose to have withheld or withdrawn the following life-prolonging procedures, when the above conditions exist:

- surgery
- heart-lung resuscitation (CPR)
- antibiotics
- mechanical ventilator (respirator)
- dialysis
- tube feedings (food and water delivered through a tube in the vein, nose or stomach)
- other \_\_\_\_\_
- If my physician believes that a certain life-prolonging procedure or other health care treatment may provide me with comfort, relieve pain or lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. However, if such treatment proves to be ineffective, I direct the treatment be withdrawn even if so doing shortens my life.
  - I direct I be given health care treatment to relieve pain or to provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.
  - I make other instructions as follows: (you may want to describe what an acceptable quality of life is) \_\_\_\_\_

- I have discussed my wishes with the following person(s) and authorize my physician to discuss my treatment and this document with them: (if you have used a Medical Durable Power of Attorney to appoint an agent, initial here \_\_\_\_\_ and include that person on the first line below.)

\_\_\_\_\_  
Name (Agent), Address, Telephone

\_\_\_\_\_  
Name, Address, Telephone

I have read these instructions and have given them careful consideration. As I have indicated, they are in accordance with my wishes.

Date \_\_\_\_\_

Signed \_\_\_\_\_

Witness \_\_\_\_\_

Witness \_\_\_\_\_