

Living Will Declaration

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

- | | | | | | |
|---|--------------------------|----|--------------------------|--------|--|
| I | <input type="checkbox"/> | do | <input type="checkbox"/> | do not | want cardiac resuscitation. |
| I | <input type="checkbox"/> | do | <input type="checkbox"/> | do not | want mechanical respiration. |
| I | <input type="checkbox"/> | do | <input type="checkbox"/> | do not | want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water). |
| I | <input type="checkbox"/> | do | <input type="checkbox"/> | do not | want blood or blood products. |
| I | <input type="checkbox"/> | do | <input type="checkbox"/> | do not | want any form of surgery or invasive diagnostic tests. |
| I | <input type="checkbox"/> | do | <input type="checkbox"/> | do not | want kidney dialysis. |
| I | <input type="checkbox"/> | do | <input type="checkbox"/> | do not | want antibiotics. |

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment. Other instructions:

- | | | | | | |
|---|--------------------------|----|--------------------------|--------|--|
| I | <input type="checkbox"/> | do | <input type="checkbox"/> | do not | want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness. |
|---|--------------------------|----|--------------------------|--------|--|

Name and address of
Surrogate
(if applicable)

Name and address of
substitute surrogate
(if surrogate designated
is unable to serve)

- | | | | | | |
|---|--------------------------|----|--------------------------|--------|--|
| I | <input type="checkbox"/> | do | <input type="checkbox"/> | do not | want to make an anatomical gift of all or part of my body, subject to the following limitations, if any: |
|---|--------------------------|----|--------------------------|--------|--|

I made this declaration on the _____ day of _____, 20_____.

Declarant's Signature: _____

Declarant's Address: _____

The declarant or the person on behalf of and at the direction of the declarant knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness's Signature: _____

Witness's Address: _____

Witness's Signature: _____

Witness's Address: _____