LIVING WILL DECLARATION

To: My Family, Doctors, and All Those Concerned with My Care

I,_____, being of sound mind, willfully and voluntarily make this directive to be followed if I become unable to participate in decisions regarding my medical care. 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 merely prolongs the dying process, if I should be in a terminal condition or in a state of permanent unconsciousness. I further direct that treatment be limited to measures to keep me comfortable and relieve pain.

You have a right to refuse treatment you do not want, and you may request the care you do want.

These directions express my legal right to refuse treatment. Therefore, I expect my doctors, family, and anyone concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes, and in so doing to be free of any legal liability for having followed my directions:

I ( ) do ( ) do not want cardiac resuscitation.
I ( ) do ( ) do not want mechanical respiration.
I ( ) do ( ) do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).
I ( ) do ( ) do not want blood or blood products.
I ( ) do ( ) do not want any form of surgery or invasive diagnostic test.
I ( ) do ( ) do not want kidney dialysis.
I ( ) do ( ) 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:

_____

_____

_____

If you want, you can name someone to see that your wishes are carried out, but you do not have to.

SURROGATE DESIGNATION

I ( ) do ( ) do not want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and be in a terminal condition or in a state of permanent unconsciousness.

Name and address of surrogate (if applicable):_____

_____

Name and address of substitute (surrogate designated above is unable to serve):_____

_____

ANATOMICAL GIFT DONATION

I ( ) do ( ) do not want to make an anatomical gift of all or part of my body, subject to the following limitations, if any: _____

_____

Sign and date here in the presence of two adult witnesses, who should also sign.

DECLARANT SIGNATURE

I made this declaration on the ____ day of _____ (month, year).

Declarant's signature:_____

Declarant's address:_____

WITNESS SIGNATURES

Witness:_____ Witness:_____

Address:_____ Address:_____

Keep the signed original with your personal papers at home. Give signed copies to doctors, family and proxy. Review your Declaration from time to time; initial and date it to show it still expresses your intent.