

**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 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 strongly about the following forms of treatment:

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

- | <b>I DO</b>              | <b>I DO NOT</b>          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Want to donate my organs upon death.  |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 |

Surrogate (name and address): \_\_\_\_\_

Substitute surrogate (name and address): \_\_\_\_\_

I made this declaration on the \_\_\_\_ day of \_\_\_\_\_ (month, year).

Declarant's signature \_\_\_\_\_ Address: \_\_\_\_\_

The declarant or a 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 signature \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_