

LIVING WILL DECLARATION

DECLARATION made this _____ day of _____, 20____,
I, _____, willfully and voluntarily make known my desire that
my dying not be artificially prolonged under the circumstances set forth below, and I do hereby
declare:

If I am terminally ill and my attending physician has determined that there can be no recovery from such condition, I direct that life prolonging procedures be withheld or withdrawn from me when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of medical care to provide comfort or alleviate pain. **I specifically direct that I receive, in any case, no artificially assisted feeding through feeding tube or gastrostomy or other artificially assisted method of delivery of sustenance;** that antibiotics not be administered; that respirators, pacemakers, renal dialysis or other mechanical devices designed to assist the functioning of organs not be utilized, that blood and blood products not be transfused, and that, in the event of cardiac or cardiopulmonary arrest, resuscitative procedures not be used. For other decisions which must be made regarding care and are not detailed above, if I am not competent to make my own decisions regarding care, I direct that the decisions of the person herein designated as my health care representative and surrogate decision maker be honored as binding on my behalf.

If I am in an end-stage condition and my attending physician has determined that my death is imminent, I direct that life prolonging procedures be withheld or withdrawn from me when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of medical care to provide comfort or alleviate pain. **I specifically direct that I receive, in any case, no artificially assisted feeding through feeding tube or gastrostomy or other artificially assisted method of delivery of sustenance;** that antibiotics not be administered; that respirators, pacemakers, renal dialysis or other mechanical devices designed to assist the functioning of organs not be utilized, that blood and blood products not be transfused, and that, in the event of cardiac or cardiopulmonary arrest, resuscitative procedures not be used. For other decisions which must be made regarding care and are not detailed above, if I am not competent to make my own decisions regarding care, I direct that the decisions of the person herein designated as my health care representative and surrogate decision maker be honored as binding on my behalf.

If I am not terminally ill, but I suffer from a persistent vegetative state, I direct that no life prolonging procedures be employed in my behalf. I specifically reject the use of respirators, pacemakers, other devices designed to assist the functioning of organs, assisted feedings, and antibiotics, and direct that these not be employed in my behalf and withhold my consent for their use. **I specifically direct that I receive, in any case, no artificially assisted feeding through feeding tube or gastrostomy or other artificially assisted method of delivery of sustenance.** I specifically reject any and all treatment which is not directed at alleviating specifically, and with high probability of success, the underlying condition causing the persistent vegetative state, and any treatment neither designed to restore my cognition nor likely to do so. Should I sustain a persistent vegetative state, I specifically request that no resuscitative efforts be made should I suffer cardiac or cardiopulmonary arrest, and withhold my consent for any such resuscitative efforts. For other care which must be decided on my behalf should I suffer a persistent vegetative state, I direct that the decisions of the person herein designated as my health care representative and surrogate decision maker be honored as binding on my behalf.

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I do not fear death itself as much as the indignities of deterioration, dependence and hopeless pain. I therefore, ask 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 or to alleviate pain.

In all cases, I want to be told about my medical condition by my doctor(s). As long as I have the ability to make decisions and communicate them, either verbally or non-verbally, then I want control over whatever decision I may make regarding treatment of my condition. However, in the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. No private or government entity shall have any control, influence or direction over the decision of my designated decision-maker.

This declaration is made after careful consideration. I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration. I hope you who care for me will feel morally bound to follow its mandate. I recognize that this appears to place a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and placing it upon myself in accordance with my strong conviction, that this declaration is made.

I authorize _____, of _____ (city), _____(state), as my health care representative and surrogate decision maker to make treatment decisions on my behalf should I be (1) diagnosed as suffering from a terminal condition, end stage condition, or persistent vegetative state, and (2) comatose, incompetent or otherwise mentally or physically incapable of communication. If _____, is unable or unwilling to serve, I authorize _____, of _____ (city), _____(state), as my health care representative and surrogate decision maker to make treatment decisions on my behalf should I be (1) diagnosed as suffering from a terminal condition, end stage condition, or persistent vegetative state, and (2) comatose, incompetent or otherwise mentally or physically incapable of communication. If both _____ and _____ are unable or unwilling to serve, I authorize _____, of _____ (city), _____(state), as my health care representative and surrogate decision maker to make treatment decisions on my behalf should I be (1) diagnosed as suffering from a terminal condition, end stage condition, or persistent vegetative state, and (2) comatose, incompetent or otherwise mentally or physically incapable of communication. I have discussed my desires concerning terminal care with the herein named persons, and I trust his/her judgment on my behalf, together with the judgment of the duly licensed physician. I understand that if I have not filled in any name in this clause, my declaration will nevertheless be given effect should the appropriate circumstances arise.

Print Name: _____

The declarant is known to me and I believe his to be of sound mind.

WITNESS: _____

WITNESS: _____

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STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of _____,
20__ by _____, [____] who is personally known to me; OR [____] who
has produced a driver's license issued within 5 years from date as identification;; OR [____] who
produced Other: _____, as identification.

Notary Public
Printed Name: _____
Commission No.: _____

My Commission Expires:
(Affix Notary Seal)

Copies of this request have been given to:

