Living Will

(Specific Form)

This is an important legal document. Read it carefully and talk about it with your doctor and family. It directs the medical treatment you are to receive in the event you are unable to participate in your own medical decisions and are terminally ill, in a permanently unconscious condition, or in a minimally conscious condition in which you are permanently unable to make decisions or express your wishes.

I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below.

Health Care:
If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or
(c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes, it is my wish that the following directions be followed by my health care provider.

While I understand that I am not legally required to be specific about future treatments **if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:**

WRITE YOUR INITIALS NEXT TO ANY STATEMENT WITH WHICH YOU AGREE:

☐ I do not want Cardiopulmonary Resuscitation (CPR), and I want my health care provider to issue a Do Not Resuscitate (DNR) order (an order written in my medical records that CPR is not to be administered to me).

☐ I do not want mechanical respiration.

☐ I do not want artificial nutrition and/or hydration (provision of foods and fluids through tubes).

☐ I do not want antibiotics.

☐ I do not want any other painful or invasive treatment that will result in prolonging my life.

☐ I want maximum pain relief, even if it may hasten my demise.

Other Instructions or Comments about My Care:

_____

_____

_____

_____

These directions express my legal right to refuse treatment. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed _____ Date _____

Address_____

Witnesses: Two witnesses must be 18 years of age or older and cannot be the health care agent or alternate.

I declare that the person who signed this document appeared to execute the Living Will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1:

Name (*please print)*: _____

Signature: _____

Address: _____

Date: _____

Witness 2:

Name (*please print)*: _____

Signature: _____

Address: _____

Date: _____