# LIVING WILL

Declaration made this ____ day of _____, 2_____.

I, (name) _____

Of (mailing address) _____

(city/state) _____ (zip) _____

(Social Security Number) _____ (Phone Number) _____

willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hearby declare:

If at any time I should have a terminal condition, ( (a) A condition caused by injury, disease, or illness for which there is no reasonable probability of recovery and which, without treatment, can be expected to cause death, or (b) A persistent vegetative state characterized by a permanent and irreversible condition of unconsciousness ) and if two (2) physicians who have personally examined me, one of whom shall be my attending physician, have determined that there can be no recovery from such condition and that my death is imminent, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would service only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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 any medical procedure deemed necessity to provide me with comfort, care or to alleviate pain.

I do ( ) do not ( ) desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this Declaration 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.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life prolonging procedures, I wish to designate, as my surrogate to carry out the provision of this Declaration:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

In the event that my first choice is unable to serve, I appoint:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional Instructions (optional): _____

_____

I understand the full import of the Declaration, and I am emotionally and mentally competent to make this Declaration.

_____ _____
(Signed) (Date)

This Declarant is known to me, and I believe him/her to be of sound mind.

_____ _____
(Witness) (Witness)

_____ _____
(Address) (Address)

_____ _____
(City/State) (City/State)

_____ _____
(Phone) (Phone)

I have been appointed and accept such appointment as the above individual's Health Care Surrogate.

_____ _____
(Health Care Surrogate's Signature #1) (Date)

_____ _____
(Health Care Surrogate's Signature #2) (Date)

This Declaration does not have to be notarized, but may be if desired.

Before me, the undersigned authority, on this _____ day of _____ 2____ personally

Appeared (Declarant) _____ Whose I.D. is _____

#1 Witness (print name) _____ Whose I.D. is _____

and #2 Witness (print name) _____ Whose I.D. is _____

or known to me to be the Declarant and the witnesses, respectively, whose names were signed to the aforegoing instrument, and who in the presence of each other, did freely subscribe their names to the attached Declaration (Living Will) on this date, and that said Declarant at the tie of execution of said Declaration was over the age of majority and of sound mind.

_____ _____
(Notary Public) (Date)

My Commission Expires: _____