LIVING WILL DECLARATION

A living will is a document that allows you to lay out your treatment preferences to sustain your life in the future. There are three areas that it covers and gives you a say in.

1. When the death of the patient is approaching due to a terminal illness even after life sustaining treatment has been attempted.
2. When the patient is permanently unconscious – this is also referred to as a persistent vegetative state.
3. When a patient has arrived at an end-stage condition brought about by the advancement of an illness and results in complete physical dependence of the patient.

As the principal, you may complete the entire document to address all three conditions or only part of the document to address the situations you believe are most relevant to you.

DESIGNATION OF AGENT

On the ___ day of _____, 20____ I, _____ (principal) of _____ [Address], with the last four digits of my social securing numbering being ____ and the telephone number _____ in sound mind and body, free of any undue influence or duress, as a mentally competent individual state that the directives provided within this document should be treated as a clear and formal declaration of my wishes as relates to my health care, treatment, and custody. I hereby declare that these instructions, outlined below, are binding upon all those involved to the full extent allowable by the law. In the event that this living will does not cover a situation that may arise, I authorize, _____ of _____ [Address], with the telephone number _____ as my agent (attorney-in-fact) to act for me and in my name according to the instructions in the document below. If the primary agent named above is unable to act on my behalf or unwilling to act on my behalf, then _____ of _____ [Address] with the telephone number _____ will be my successor agent.

LIFE-SUSTAINING MEDICAL TREATMENT

In some cases, people do not which to have certain life sustaining treatments used under any circumstances. If there are certain treatments or procedures that you DO NOT want medical care professionals to use to sustain your life, please initial next to them below. Leave them blank if you wish for them to use all of the available options if the situation arises.

____ Cardiopulmonary resuscitation with the aim of extending my life

____ Using external life support devices such as respirators or ventilators perform regular bodily functions to extend my life

____ Using external life support devices such as tube feeding or intravenous lines to deliver nutrition with the aim of extending my life

____ Using blood or blood products to extend my life

____ Using artificial dialysis machines to extend my life

____ Using antibiotics and other medications to extend my life

____ Other _____

I understand that if I DO NOT initial any treatment option above then I give my consent for that treatment to be used if it is required.

PREFERENCES FOR TERMINAL ILLNESS

(Initial only one of the options below. Leave blank if you have no preferences)

In the event that my death is near due to a terminal illness even with the use of life-sustaining treatments, then:

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. I also do not want additional fluids and or nutrition via medical means or tubes.

Or

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

Or

_____ I wish for my health care providers to try and extend my life for as long as possible. Take advantage of all available treatment methods, procedures, and interventions that, under reasonable expectations, would prevent or delay my death. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

PREFERENCES FOR PERSISTENT VEGITATIVE STATE

(Initial only one of the options below. Leave blank if you have no preferences)

If it has by determined by my physicians that I am in a persistent vegetative state – I have no awareness of my surroundings or myself, I am not conscious, and I am unable to interact with others and there is no expectation due to prevailing medical techniques and treatment methods for me to regain consciousness – then:

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. I also do not want additional fluids and or nutrition via medical means or tubes.

Or

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

Or

_____ I wish for my health care providers to try and extend my life for as long as possible. Take advantage of all available treatment methods, procedures, and interventions that, under reasonable expectations, would prevent or delay my death. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

PREFERENCES FOR END OF STAGE CONDITION

(Initial only one of the options below. Leave blank if you have no preferences)

If it has been determined by my physicians that I am in an end-state conditions – an condition that current medicine has no cure for and which will progress until I die and has already created a significant loss of overall capacity and total physical dependency – then:

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. I also do not want additional fluids and or nutrition via medical means or tubes.

Or

_____ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

Or

_____ I wish for my health care providers to try and extend my life for as long as possible. Take advantage of all available treatment methods, procedures, and interventions that, under reasonable expectations, would prevent or delay my death. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

COMFORT AND PAIN RELIEF

(Initial one option below to share your pain relief preferences. If you have none then leave this section blank)

In line with my aforementioned decisions, I would like to take the following approach to my comfort and pain relief:

____ I wish to utilize maximum pain relief medication and treatment options as long as it does not hasten my death.

____ I wish to utilize maximum pain relief medication and treatment options even if it hastens my death.

____ I wish to utilize maximum pain relief medication and treatment options even if it will result in addiction if I survive my current condition or an extended hospital stay.

____ Other _____

_____

IN THE CASE OF PREGNANCY

(This is optional and should only be filled out by women of child-bearing age. If it is not applicable to you then leave blank).

If it occurs that I am pregnant and need life-sustaining treatment, my preferences will change as follows:

_____

_____

_____

END OF LIFE WISHES

(this section should outline things such as hospice care, funeral arrangements, etc.)

When the time of my death draws near, it is important to me that my affairs are handled in the following manner:

_____

_____

_____

SIGNATURE AND ACKNOWLEDGEMENT

_____ _____

Signature of Declarant Date

_____

Name Printed

_____

Address

_____

Telephone Number

We, serving as witnesses, each declare that the declarant signed and executed this instrument in our presence. The declarant signed it in their right state of mind, to our knowledge is eighteen years of age or older, and willingly signed without undue pressure, influence, or duress. We each sign this power of attorney as witnesses at the request of the principal while the principal is present.

_____

Witness's Signature

_____

Address

_____

Witness's Signature

_____

Address

Notary Acknowledgement

State of _____

County of _____

On _____, 20____ before me, _____ (name and title of officer), personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose names are subscribed within the instrument and acknowledged to me that they executed the same in their authorized capacity(ies), and that by their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

Print Name _____