Living Will Declaration and Directive to Physicians of _____

Notice to Adult Signing This Document: This is an important legal document. This document directs the medical treatment you are to receive in the event you are unable to participate in your own medical decisions and you are in a terminal condition. This document may state what kind of treatment you want or do not want to receive. This document can control whether you live or die. Prepare this document carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes. This document will remain valid and in effect until and unless you revoke it. Review this document periodically to make sure it continues to reflect your wishes. You may amend or revoke this document at any time by notifying your physician and other health-care providers. You should give copies of this document to your physician and your family. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the three witnesses whom you have selected and a notary public.

I, _____ , being of sound mind, willfully and voluntarily make known my desire that my life not be artificially prolonged under the circumstances set forth below, and, pursuant to any and all applicable laws in the State of _____ , I declare that:

If at any time I should have an incurable injury, disease, or illness which has been certified as a terminal condition by my attending physician and one additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition and my death is imminent, and where the application of life prolonging procedures would serve only to artificially prolong the dying process, then:

I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the administration of nutrition and/or hydration, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

If at any time I should have been diagnosed as being in a persistent vegetative state which has been certified as incurable by my attending physician and one additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition, and where the application of life prolonging procedures would serve only to artificially prolong the dying process, then:

I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the administration of nutrition and/or hydration, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

In the absence of my ability to give directions regarding my treatment in the above situations, including directions regarding the use of such life prolonging procedures, then:

It is my intention that this declaration shall be honored by my family, my physician, and any court of law, as the final expression of my legal right to refuse medical and surgical treatment. I declare that I fully accept the consequences for such refusal.

If I have any additional directions, I will state them here:

If I have also signed a Health Care Power of Attorney, Appointment of Health Care Agent, or Health Care Proxy, I direct the person who I have appointed with such instrument to follow the directions that I have made in this document. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

If I am diagnosed as pregnant, this document shall have no force and effect during my pregnancy.

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration and Living Will. I also understand that I may revoke this document at any time.

I publish and sign this Living Will and Directive to Physicians, consisting of _____ typewritten pages, on _____ , 20_____ , and declare that I do so freely, for the purposes expressed, under no constraint or undue influence, and that I am of sound mind and of legal age.

_____
Declarant's Signature

_____
Printed Name of Declarant

On _____ , 20_____ , in the presence of all of us, the above-named Declarant published and signed this Living Will and Directive to Physicians, and then at the Declarant's request, and in the Declarant's presence, and in each other's presence, we all signed below as witnesses, and we each declare, under penalty of perjury, that, to the best of our knowledge:

1. The Declarant is personally known to me and, to the best of my knowledge, the Declarant signed this instrument freely, under no constraint or undue influence, and is of sound mind and memory and legal age, and fully aware of the possible consequences of this action.

2. I am at least 19 years of age and I am not related to the Declarant in any manner: by blood, marriage, or adoption.

3. I am not the Declarant's attending physician, or a patient or employee of the Declarant's attending physician; or a patient, physician, or employee of the health care facility in which the Declarant is a patient, unless such person is required or allowed to witness the execution of this document by the laws of the state in which this document is executed.

4. I am not entitled to any portion of the Declarant's estate on the Declarant's death under the laws of intestate succession of any state or country, nor under the Last Will and Testament of the Declarant or any Codicil to such Last Will and Testament.

5. I have no claim against any portion of the Declarant's estate on the Declarant's death.

6. I am not directly financially responsible for the Declarant's medical care.

7. I did not sign the Declarant's signature for the Declarant or on the direction of the Declarant, nor have I been paid any fee for acting as a witness to the execution of this document.

_____
Signature of Witness #1

_____
Printed name of Witness #1

_____
Address of Witness #1

_____
Signature of Witness #2

_____
Printed name of Witness #2

_____
Address of Witness #2

_____
Signature of Witness #3

_____
Printed name of Witness #3

_____
Address of Witness #3

County of _____
State of _____

On _____ , 20_____, before me personally appeared _____ , the Declarant, and _____, the first witness, _____ , the second witness, _____ , the third witness, and, being first sworn on oath and under penalty of perjury, state that, in the presence of all the witnesses, the Declarant published and signed the above Living Will Declaration and Directive to Physicians, and then, at Declarant's request, and in the presence of the Declarant and of each other, each of the witnesses signed as witnesses, and stated that, to the best of their knowledge, the Declarant signed said Living Will Declaration and Directive to Physicians freely, under no constraint or undue influence, and is of sound mind and memory and legal age and fully aware of the potential consequences of this action. The witnesses further state that this affidavit is made at the direction of and in the presence of the Declarant.

_____
Signature of Notary Public

_____
Printed name of Notary Public

Notary Public,
In and for the County of _____
State of _____
My commission expires: _____ Notary Seal