

ADVANCE DIRECTIVE - LIVING WILL

Declaration made this ____ day of _____, 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 at any time I am incapacitated, and I have a terminal condition, or I have an end-stage condition, or I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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 any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

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.

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

OPTIONAL PROVISIONS:

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 provisions of this declaration:

Name: _____
Address: _____ Zip Code: _____
Phone: _____

Additional Instructions (check)

- I do not want nutrition (food) to be provided to me if these procedures would serve only to prolong artificially the process of dying.
- I do not want hydration (water) to be provided to me if these procedures would serve only to prolong artificially the process of dying.
- I want nutrition (food) provided to me at all times, even if these procedures would serve only to prolong artificially the process of dying.
- I want hydration (water) provided to me at all times, even if these procedures would serve only to prolong artificially the process of dying.

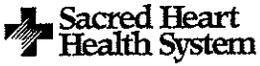
Signed: _____

[Neither witness can be a designated surrogate. One of the witnesses must be unrelated (by blood or marriage) to Principal:]

Witness _____
Address _____
Telephone Number _____

Witness _____
Address _____
Telephone Number _____





DESIGNATION OF HEALTH CARE SURROGATE

Name of Principal: _____
(Last) (First) (Middle Initial)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____ Phone: _____

Address: _____

If my surrogate is unwilling or unable to perform his duties, I wish to designate as my alternate surrogate:

Name: _____ Phone: _____

Address: _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical-gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; to authorize my admission to or transfer from a health care facility; and to authorize the withholding or withdrawing of life-prolonging procedures.

Additional instructions (optional): _____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: _____

Name: _____

PRINCIPAL

DATE

[Neither witness can be a designated surrogate. One of the witnesses must be unrelated (by blood or marriage) to Principal]:

Witness

Witness



ADLW