Living Will

AN ADVANCE DIRECTIVE TO MY FAMILY, MY PHYSICIANS AND ANY HEALTH CARE FACILITY

I,_____ REALIZE THAT AT SOME POINT IN MY LIFE I WILL HAVE AN ILLNESS,INJURY OR ANY CONDITION THAT MIGHT BE THE CAUSE OF MY DEATH. WHEN THAT HAPPENS, AND MY DOCTOR DOES NOT EXPECT ME TO RECOVER AND DEATH IS NEAR, I WANT MY DEATH TO OCCUR NATURALLY. I WANT ALL TREATMENTS THAT WOULD ONLY PROLONG MY DYING TO BE STOPPED OR NOT USED. IF I AM UNABLE TO EAT OR DRINK,

IDO_____ I DO NOT _____

WANT FOOD OR WATER TO BE GIVEN ARTIFICAILLY. I UNDERSTAND AND DESIRE THAT MEDICINE AND TREATMENTS THAT RELIEVE PAIN AND KEEP ME COMFORTABLE WILL CONTINUE TO BE USED. SPECIFIC CONCERNS OR INSTRUCTIONS FOR MY PHYSICIANS ARE AS
FOLLOWS:_____
_____
_____
_____
_____

IF I AM UNABLE TO EXPRESS MYSELF I EXPECT MY INSTRUCTIONS TO BE FOLLOWED BY MY PHYSICIANS, FAMILY AND FRIEND. I AM OF SOUND MIND AND UNDERSTAND THE IMPORTANCE OF THIS REQUEST.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DESIGNATION

(OPTIONAL)

IT IS MY WISH THAT IF I HAVE AN ILLNESS OR CONDITION THAT IS GOING TO CAUSE MY DEATH,

AND I AM UNABLE TO EXPRESS MYSELF, I APPOINT_____

WHO LIVES AT _____

ADDRESS_____ PHONE_____

TO MAKE TREATMENT DECISIONS FOR ME. THIS DESIGNATION SHALL BE CONSTRUCTED AS A

DURABLE POWER OF ATTORNEY FOR HEALTHCARE, AND SHALL NOT BE AFFECTED BY MY DISABILITY AS PROVIDED BY STATUE.

I UNDERSTAND THAT IF I AM DIAGNOSED AS PREGNANT AND MY PHYSICANS IS AWARE OF TH DIAGNOSIS THIS DECLARATION BECOMES INVALID.

I SIGN THIS STATEMENT OF MY OWN FREE WILL THIS _____ DAY OF _____, 20_____

_____

SIGNATURE

I KNOW THE PERSON SIGNING THIS “LIVING WILL,”AND I BELIEVE HIM/HER TO BE OF SOUND AND MIND

WITNESS_____ DATE_____

WITNESS_____DATE_____