

LIVING WILL

ADVANCE DIRECTIVE FOR HEALTH CARE — TREATMENT INSTRUCTIONS

DECLARANT

DATE

I, the Declarant identified below, make this Living Will voluntarily while capable of making health-care decisions. These instructions express my wishes if I later cannot communicate or make an informed decision and the clinical conditions stated herein are met.

1 DECLARANT INFORMATION

This directive is made by the following adult.

FULL LEGAL NAME

FULL ADDRESS

DATE OF BIRTH

PHONE

STATE

MEDICAL RECORD NO. (OPTIONAL)

2 WHEN THIS DIRECTIVE APPLIES

My instructions apply when I lack decision-making capacity and the condition selected below has been determined as required by applicable state law.

Applicable condition — select all intended:

☐ Terminal condition

☐ Permanent unconsciousness / persistent vegetative state

☐ End-stage condition

☐ Other condition stated below

OTHER CONDITION / REQUIRED CLINICAL FINDING

3 GENERAL TREATMENT DIRECTION

Select the direction that best states my wishes. Comfort care and pain relief should always be provided unless I specifically direct otherwise.

Treatment preference — select one:

☐ Prolong life using medically appropriate treatment

☐ Withhold or withdraw life-prolonging treatment; provide comfort care

☐ Follow the specific instructions below

4 SPECIFIC TREATMENT INSTRUCTIONS

My preferences for particular treatments are recorded below. If an item is not addressed, my agent (if any) and health-care providers should follow my known wishes and applicable law.

CPR · WANT / DECLINE

VENTILATION · WANT / DECLINE

ARTIFICIAL NUTRITION · WANT / DECLINE

ARTIFICIAL HYDRATION · WANT / DECLINE

DIALYSIS · WANT / DECLINE

ANTIBIOTICS · WANT / DECLINE

HOSPITALIZATION · WANT / DECLINE

TREATMENT TRIAL PERIOD

5 COMFORT CARE & PAIN RELIEF

I direct that medication, nursing care, oxygen, hygiene, warmth, positioning, and other measures needed for comfort and relief of pain or distress be provided, even if such care may indirectly shorten my life, to the extent permitted by law.

ADDITIONAL COMFORT / PALLIATIVE-CARE INSTRUCTIONS

6 HEALTH-CARE AGENT / PROXY (IF SEPARATELY APPOINTED)

This Living Will does not by itself expand an agent's authority beyond applicable law or a separate health-care power of attorney. The person identified below should receive and help communicate these instructions if legally authorized.

AGENT / PROXY NAME

RELATIONSHIP

PHONE

EMAIL

7 PREGNANCY, ANATOMICAL GIFTS & OTHER WISHES

Any pregnancy limitation imposed by state law applies. My organ, tissue, autopsy, and disposition preferences are stated below or in a separate legally valid document.

PREGNANCY-SPECIFIC INSTRUCTIONS (IF APPLICABLE)

ORGAN / TISSUE DONATION & OTHER WISHES

8 REVOCATION & COPIES

I understand that I may revoke this directive while capable by any method permitted by state law. A copy or electronic copy may be relied on as the original where lawful. I intend this directive to remain effective until revoked.

ADDITIONAL HEALTH-CARE INSTRUCTIONS

9 EXECUTION & WITNESS DECLARATION

I sign this directive voluntarily, understand its purpose and effect, and affirm that the instructions above express my wishes. The witnesses attest that I signed or acknowledged this directive in their presence, appeared capable and free from duress, and that each witness meets the qualifications required by the governing state.

DECLARANT SIGNATURE

PRINT NAME

DATE

WITNESS SIGNATURE (IF REQUIRED)

DATE

WITNESS SIGNATURE (IF REQUIRED)

DATE

WITNESS 1 - PRINT NAME

WITNESS 1 - ADDRESS

WITNESS 2 - PRINT NAME

WITNESS 2 - ADDRESS

10 NOTARY ACKNOWLEDGMENT — ALTERNATIVE TO WITNESSES WHERE ALLOWED (if required or selected)

ACKNOWLEDGMENT

State of , County of

On (date), before me personally appeared

the above-named person(s), known to me or satisfactorily proven to be the person(s) whose name(s) are subscribed to this instrument, and acknowledged that they executed it for the purposes stated herein.



NOTARY PUBLIC SIGNATURE

COMMISSION EXPIRES