LIVING WILL

This document is a preliminary measure taken in case there ever comes a time when you can no longer communicate your health care wishes to your doctors. The Living Will allows you to tell your health care providers your preferences for end of life treatment.

This form was completed and signed on ____ day of _____,20____.

Health Care Directive

I, _____, with a street address of _____, City of _____, County of _____, State of _____, with the last four (4) digits of my social security number (SSN) being xxx-xx-_____ (Hereinafter may be referred to as the 'Principal') desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

1) *LIFE SUPPORT*:

I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

_____ ☐ Chronic coma or persistent vegetative state.

_____ ☐ No longer able to communicate my needs.

_____ ☐ No longer able to recognize family or friends.

_____ ☐ Total dependence on others for daily care.

_____ ☐ Other: _____

Initial and check *only* one:

_____ ☐ Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).

_____ ☐ If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

2) *CERTAIN LIFE-SUSTAINING TREATMENT*: (You do not have to initial and check any of these if you do not wish to.)

Some people do not wish to have certain life sustaining treatments under any circumstance, even if recovery is a possibility. Check treatments below, if any, that you do not wish to have under any circumstances:

_____ ☐ Cardiopulmonary Resuscitation (CPR)

_____ ☐ Ventilation (breathing machine)

_____ ☐ Feeding Tube

_____ ☐ Dialysis

_____ ☐ Other: _____

3) *END OF LIFE WISHES*: (hospice care, funeral arrangements, etc.):

When I am near death, it is important to me that:

_____

_____

_____

_____

I have signed this document on this ____ day of _____, 20____.

_____ _____

Principal's Signature Printed Name

_____ _____

Address Phone Number

(You may either choose ***two (2) witnesses*** or a ***notary public*** to observe and acknowledge your signature on the next page.)

WITNESS ACKNOWLEDGMENT

On the date set forth above, I hereby state as follows:

The above-named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and I am not an agent or successor agent named in this document. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness #1's Signature _____ Printed Name _____

Address _____ Phone Number _____

Witness #2's Signature _____ Printed Name _____

Address _____ Phone Number _____

NOTARY ACKNOWLEDGMENT

State of _____}

County of _____}

Signed and sworn to me on the ___ day of _____, in the year 20___.

I, the undersigned authority in and for said County in said State, hereby certify that the **Principal** _____, whose name is signed above in this living will, and who is known to me, acknowledged before me on this day that, being informed of the contents of the said document, (s)he executed the same voluntarily on the day the same bears date.

Given under my hand this ___ day of _____, 20___.

Notary Public Signature _____ State of _____

Printed Name _____

My commission expires _____

(Notary Seal)