Need some help filling out your Living Will document below?

You can now fill out a customized step-by-step version of this form and many others (your Will, Health Care Power of Attorney, and more) completely free on doyourownwill.com! And instantly download as .docx and .pdf.

Follow this link back to doyourownwill to begin: Your Estate Planning Guide

Last Will and Testament

Distribute your property, name guardians, and appoint an executor.

Living Will

Let others know your health care decisions.

Durable Power of Attorney

Appoint someone to communicate your decisions if you can't.

Or feel free to complete the blank form found below.

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS: This form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. This form also lets you express an intention to donate your bodily organs and tissues following your death. Lastly, this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health-care agents you have named.

I, _________________, being of sound mind and at least 18 years of age, declare that:

(1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Initial only one box)

- [___] (a) Choice NOT To Prolong Life. I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR
- [___] (b) Choice To Prolong Life. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment:

I (___) do (___) do not want cardiac resuscitation.
I (___) do (___) do not want mechanical respiration.
I (___) do (___) do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).
I (___) do (___) do not want blood or blood products.
I (___) do (___) do not want any form of surgery or invasive diagnostic tests.
I (___) do (___) do not want kidney dialysis.
I (___) do (___) do not want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

(2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

____
____
____.

(3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

____
____
____

(4) PRIMARY PHYSICIAN: (OPTIONAL)

- I designate the following physician as my primary physician:

  ____

  (name of physician)

  ____

  (address) (city) (state) (zip code)

  ____

  (phone)

  OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

  ____

  (name of physician)

  ____

  (address) (city) (state) (zip code)

  ____

  (phone)

(5) DONATION OF ORGANS AT DEATH: (OPTIONAL)

Upon my death: (mark applicable box)

- [___] (a) I give any needed organs, tissues, or parts, OR
- [___] (b) I give the following organs, tissues, or parts only.

  ____

  ____

  ____

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from such refusal.

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

I execute this declaration, as my free and voluntary act, on this ______ day of ________________, 20__, in the City of , County of __________________, State of __________________.

____

(signature)

(INSTRUCTIONS: This advance health care directive will not be valid for making health care decisions unless it is either: (1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (2) acknowledged before a notary public.)

I declare under penalty of perjury under the laws of the state of (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual’s health care provider, an employee of the individual's health care provider, the operator of a community health care facility, the operator of a community health care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

I further declare under the laws of penalty of perjury of the state of that I am neither related to the patient by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any portion of the patient's estate upon the patient's death under a will existing when the advance directive is executed or by operation of law.

Signed on this ____ day of ______________, 20__.

____

(name and address of first witness)

____

(name and address of second witness)

On this the ________ day of __________________, 20__, before me, the undersigned, a notary public in and for said County and State, personally appeared _______________________________, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

____

(Signature of Notary)