

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](http://doyourownwill.com) 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.

DECLARATION

I, _____, declare on this _____ day of _____, 20__ that I have made the following decision concerning life-prolonging treatment:

CHOOSE ONE OPTION BY PLACING YOUR INITIALS NEXT TO CHOICE (#1, #2, OR #3)

_____ (1) I direct life-prolonging treatment be withheld or withdrawn and I be permitted to die naturally if two physicians certify that:

- (a) I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death;
- (b) The application of life-prolonging treatment would serve only to artificially prolong the process of my dying ; and
- (c) I am not pregnant.

It is my intention this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and they accept the consequences of that refusal, which is death.

_____ (2) I direct life-prolonging treatment, which could extend my life, be used if two physicians certify that I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death. It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to direct that medical or surgical treatment be provided.

_____ (3) I make no statement concerning life-prolonging treatment.

CHOOSE ONE OPTION BY PLACING YOUR INITIALS NEXT TO CHOICE (#1, #2, #3, OR #4)

I have made the following decision concerning the administration of nutrition when my death is imminent:

_____ (1) I wish to receive nutrition.

_____ (2) I wish to receive nutrition unless I cannot physically assimilate nutrition, nutrition would be physically harmful or would cause unreasonable physical pain, or nutrition would only prolong the process of my dying.

_____ (3) I do not wish to receive nutrition.

_____ (4) I make no statement concerning the administration of nutrition.

CHOOSE ONE OPTION BY PLACING YOUR INITIALS NEXT TO CHOICE (#1, #2, #3, OR #4)

_____ (1) I wish to receive hydration.

_____ (2) I wish to receive hydration unless I cannot physically assimilate hydration, hydration would be physically harmful or would cause unreasonable physical pain, or hydration would only prolong the process of my dying.

_____ (3) I do not wish to receive hydration.

_____ (4) I make no statement concerning the administration of hydration.

Concerning the administration of nutrition and hydration, I understand that if I make no statement about nutrition or hydration, my attending physician may withhold or withdraw nutrition or hydration if the physician determines I cannot physically assimilate nutrition or hydration or that nutrition or hydration would be physically harmful or would cause unreasonable physical pain.

If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration is not effective during the course of any pregnancy.

I understand the importance of this declaration, I am voluntarily signing this declaration,

I am at least 18 (eighteen) years of age, and I am emotionally and mentally competent to make this declaration.

I understand that I may revoke this declaration at any time.

Signed on this _____ day of _____, 20___, in the City of _____, County of _____, State of _____.

(signature)

_____ is personally known to me and I believe him or her to be of sound mind. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate upon the declarant's death. I am not the declarant's attending physician, a person who has a claim against any portion of the

declarant's estate upon the declarant's death, or a person directly financially responsible for the declarant's medical care.

First Witness:

_____, residing at _____

(Signature Above)

Second Witness:

_____, residing at _____

(Signature Above)