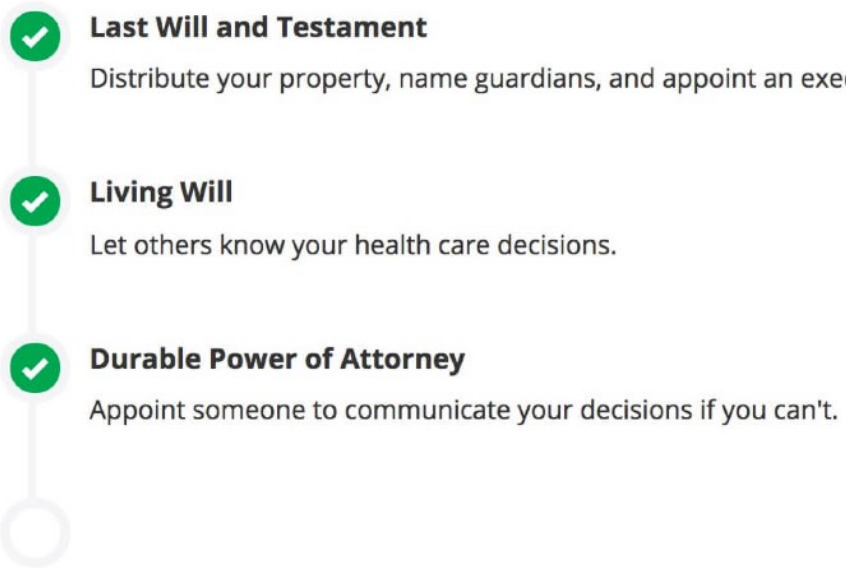
Need some help filling out your Living Will document below?

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]



Or feel free to complete the blank form found below.

Advance Directive for Health Care

I, _____, being of sound mind and eighteen (18) years of age or older, willfully and voluntarily make known my desire, by my instructions to others through my living will, or by my appointment of a health care proxy, or both, that my life shall not be artificially prolonged under the circumstances set forth below. I thus do hereby declare:

I. LIVING WILL

A. If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act, to withhold or withdraw treatment from me under the circumstances I have indicated below by my signature. I understand that I will be given treatment that is necessary for my comfort or to alleviate my pain.

B. If I have a terminal condition:

(1) I direct that life-sustaining treatment shall be withheld or withdrawn if such treatment would only prolong my process of dying, and if my attending physician and another physician determine that I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

_____
(signature)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) that will only prolong the process of dying from an incurable and irreversible condition is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

_____
(signature)

(3) I direct that (add other medical directives, if any)

_____
_____
_____
_____.

_____
(signature)

C. If I am persistently unconscious:
(1) I direct that life-sustaining treatment be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

_____
(signature)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) for individuals who have become persistently unconscious is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

_____
(signature)

(3) I direct that (add other medical directives, if any)
_____
_____
_____
_____.

_____
(signature)

MY APPOINTMENT OF MY HEALTH CARE PROXY

A. If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act to follow the instructions of _____, whom I appoint as my health care proxy. If my health care proxy is unable or unwilling to serve, I appoint _____ as my health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment can be made by my health care proxy or alternate health care proxy only as I indicate in the following sections.

B. If I have a terminal condition:

(1) I authorize my health care proxy to direct that life-sustaining treatment be

withheld or withdrawn if such treatment would only prolong my process of dying and if my attending physician and another physician determine that I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

_____
(signature)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) that will only prolong the process of dying from an incurable and irreversible condition is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

_____
(signature)

(3) I authorize my health care proxy to (add other medical directives, if any,)
_____
_____
_____.

_____
(signature)

C. If I am persistently unconscious:

(1) I authorize my health care proxy to direct that life-sustaining treatment be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

_____
(signature)

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) for individuals who have become persistently unconscious is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

_____

(signature)

(3) I authorize my health care proxy to (add other medical directives, if any)
_____
_____
_____.

_____
(signature)

ANATOMICAL GIFTS

I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of transplantation, therapy, advancement of medical or dental science or research or education pursuant to the provisions of the Uniform Anatomical Gift Act. Death means either irreversible cessation of all circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem.

I specifically:

A. I desire to donate my entire body.

_____
(signature)

B. I desire to donate the following body organs or parts:
_____
_____

_____
(signature)

C. I DO NOT desire to donate my entire body or any specific organs or tissues for transplantation.

_____
(signature)

CONFLICTING PROVISION

I understand that if I have completed both a living will and have appointed a health care proxy, and if there is a conflict between my health care proxy's decision and my living will, my living will shall take precedence unless I indicate otherwise.

_____
(signature)

GENERAL PROVISIONS

If I have been diagnosed as pregnant at the time this document is to be effective, and that diagnosis is known to any interested person, then this document shall have no force and effect during the time of my pregnancy.

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 accept the consequences from such refusal.

This advance directive shall be in effect until it is revoked.

I understand that I may revoke this advance directive at any time.

I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.

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

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

_____
(signature)

_____ voluntarily signed this writing in my presence. I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, or an employee of an operator of a residential care facility for the elderly.

I declare under penalty of perjury under the laws of the State of that the foregoing is true and correct.

Executed on this _____ day of the month of _____, 20__, in the County of _____, State of _____.

First Witness:

_____, residing at _____

(Signature Above)

Second Witness:

_____, residing at _____

(Signature Above)