

## 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](http://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.

## DIRECTIVE TO PHYSICIANS

Directive made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_. I, \_\_\_\_\_, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians, one of whom is the attending physician, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

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.

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)

I hereby witness this declaration and attest that:

- (1) I personally know the Declarant and believe the Declarant to be of sound mind.
- (2) To the best of my knowledge, at the time of the execution of this declaration, I:
  - (a) Am not related to the Declarant by blood or marriage,
  - (b) Do not have any claim on the estate of the Declarant,
  - (c) Am not entitled to any portion of the Declarant's estate by any will or by operation of law, and
  - (d) Am not a physician attending the Declarant, a person employed by a physician attending the Declarant or a person employed by a health facility in which the Declarant is a patient.
- (3) I understand that if I have not witnessed this directive in good faith I may be responsible for any damages that arise out of giving this directive its intended effect.

By my signature on this directive, I attest the Declarant signed this document in my presence and in the presence of other said witness.

I declare under penalty of perjury under the laws of the State of Oregon 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)

\_\_\_\_\_

Print Name Above

**Second Witness:**

\_\_\_\_\_, residing at \_\_\_\_\_

(Signature Above)

\_\_\_\_\_

Print Name Above