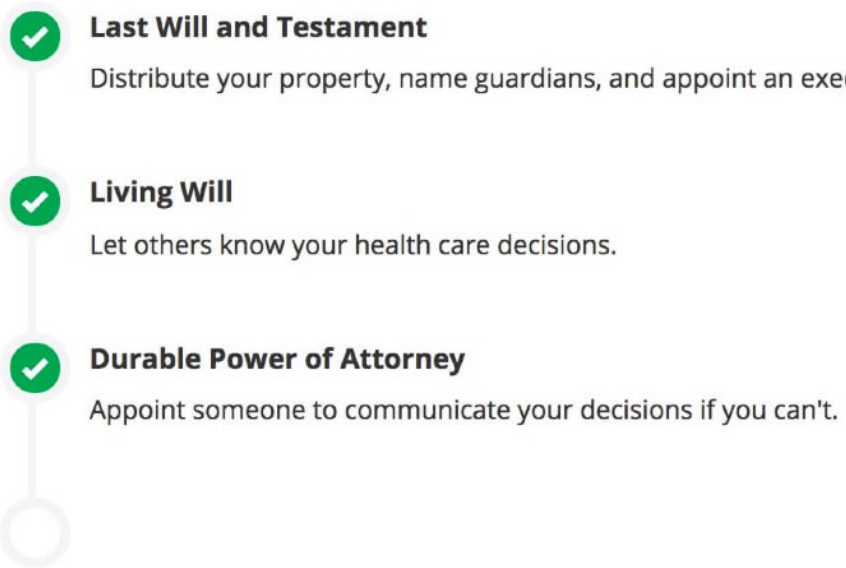
Need some help filling out your Living Will document below?

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.

INSTRUCTIONS FOR HEALTH CARE

(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:

[__] (a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death in a relatively short time, (ii) I become unconscious and, to a reasonable degree medical certainty, I will not regain consciousness or (iii) the likely risks and burdens of treatment could 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.

(2) ARTIFICIAL NUTRITION AND HYDRATION: If I have selected the above choice NOT to prolong life under specified conditions, I also specify that I ____ do or ____ do not want artificial nutrition and hydration provided to me.

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

_____

_____

(4) OTHER WISHES: (If you wish to write your own instructions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(5) EFFECT OF COPY: A copy of this form has the same effect as the original.

(6) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health-care provider and any health-care institution where I am receiving care and any others to whom I have given copies of this document. I understand that I may revoke the designation of an agent only by a signed writing or by personally informing the supervising health-care provider.

(7) SIGNATURES: Sign and Date the form here:

_____

(signature)

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

SIGNATURES OF WITNESSES

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)