

LIVING WILL (HEALTH CARE DIRECTIVE) OF

Patient's Name: _____

Address: _____

Date of Birth: _____, 20____

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have the decisional capacity, have a terminal condition, or become permanently unconscious have been indicated by checking and initialing the appropriate lines below:

By checking and initializing the line below:

- _____ I **CHOOSE** to elect a Surrogate.

I designate _____ as my health care surrogate ("Surrogate") to make health care decisions for me in accordance with this directive when I no longer have decisional capacity. If my Surrogate refuses or is not able to act for me, I designate _____ as my secondary surrogate to hold the same powers.

Any prior designation is hereby revoked.

- _____ I **DO NOT** choose to elect a Surrogate.

If I do not elect a Surrogate, the following are my directions to my attending physician. If I have elected a Surrogate, my Surrogate shall comply with my wishes as indicated by checking and initialing the lines below:

Life Prolonging Treatment (check and initial only one)

- _____ - Direct that treatment be **WITHHELD** or **WITHDRAWN** and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

- _____ - **DO NOT** authorize that life-prolonging treatment be withheld or withdrawn.

Nourishment and / or Fluids (check and initial only one)

- _____ - Direct that treatment be **WITHHELD** or **WITHDRAWN** and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.
- _____ - **DO NOT** authorize that life-prolonging treatment be withheld or withdrawn

Surrogate Determination of Best Interest

NOTE: If you desire this option, **DO NOT** choose any of the preceding options regarding Life Prolonging Treatment and Nourishment and / or Fluids.

- _____ - Authorize my surrogate, as designated on the previous page, to withhold or withdraw artificially provided nourishment or fluids, or other or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

Organ / Tissue / Eye Donation

I certify to be eighteen (18) years of age or older and of sound mind, and that upon my death, I hereby give: (check the appropriate boxes and initial the line beside that box)

- _____ - Any needed organs, tissues, and eyes/corneas.

OR

The following organs or tissues only:

- _____ - All needed organs
- _____ - All needed tissues
- _____ - Corneas
- _____ - Eyes
- _____ - Other: _____.

OR

- _____ - Only the specified organs/tissues as listed:

Notice to Medical Staff

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

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

Patient's Signature: _____ **Date:** _____

Two (2) adult witnesses **OR** a notary public must accompany this signature.

2 Witnesses

In our joint presence, the patient, who is of sound mind and at least eighteen (18) years of age, voluntarily dated and signed this writing or directed it to be dated and signed for the patient.

Witness's Signature: _____ **Date:** _____
Print Name: _____
Mailing Address: _____

Witness's Signature: _____ **Date:** _____
Print Name: _____
Mailing Address: _____

Notary Public

State of _____ }
County of _____ }

Before me, the undersigned authority, came under the patient who is of sound mind and eighteen (18) years of age or older, and acknowledged that he/she voluntarily dated and signed this writing or directed it to be signed and dated as above.

This document was signed on _____, 20_____

(seal)

Notary Public: _____
Print Name: _____
My Commission Expires: _____, 20_____