ADVANCE DIRECTIVES - LIVING WILL

Declaration made this ___ day of _____, 2007, in the City of _____, State of _____, stating that I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth by me below. I do hereby declare that if, at any time, I am mentally or physically incapacitated with a terminal condition, or end-stage disease, or any disease that is irreversible and hopeless, or, quadriplegia, or, if I am in a vegetative disease, and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition(s), I direct that life-prolonging procedures be withheld or withdrawn when application of such procedures would serve only to artificially prolong the process of dying, and that cardiopulmonary resuscitation not be performed when I go into a cardiac or respiratory arrest, and I be permitted to die naturally with only the administration of medication(s) or the performance of any medical procedure deemed necessary to provide me with comfort care and to alleviate my pain and suffering with adequate narcotics, and to allow me to die with dignity.

I want a DNR (Do Not Resuscitate) order to be made, instituted, and implemented when any of those specified hopeless conditions, or any combination thereof, have afflicted me.

I desire that no intravenous nutrition be given me, but oral feeding be allowed only when I asked for it. I want intravenous fluid hydration be withheld or withdrawn when application of such procedures would serve only to delay artificially the process of dying and unnecessarily prolong my pain, suffering and agony from an incurable and hopeless condition(s). An open intravenous line may be maintained, only for the purpose of administration of pain medications to keep me pain free.

It is my intention that this declaration be faithfully honored by my family, guardian, and physician as the final expression of my legal rights to refuse medical or surgical treatment, and nutrition and hydration as stipulated above, and I fully accept the sole responsibility and consequences for such refusal.

In the event I have been determined to be incapacitated and unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures or treatment, I wish to designate, as my surrogate (and alternate surrogates, in the order I have listed below) to carry out my wishes and the provisions of this declaration as my health care agent and attorney-in-fact.

Name: _____

Address: _____

City: _____State: _____

Phone: _____

In the event the above-named individual is unable, or unwilling, to act and perform the duties as my surrogate, the next one on the list of two names below shall fulfill said duties, in this order:

Name: _____

Address: _____

City: _____ State: _____

Phone: _____

Name: _____

Address: _____

City: _____ State: _____

Phone: _____

If the three above are unable or unwilling, then the list will include my other children, according to their date of birth in descending order, as alternate surrogates.

I understand the full importance and implications of this declaration, and I am emotionally and mentally competent to make this declaration at this writing.

Additional Information (if any): _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply, if needed, for public benefits to defray the cost of healthcare; and to authorize admission to or transfer from a health care facility.

If it becomes necessary for a court to appoint a guardian of my person, I nominate my surrogate health care agent acting under this document to be the guardian of my person, to serve without bond or security.

No person who relies in good faith upon the authority of, or any representations by my health care agent, shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent.

The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf.

All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

I am holding harmless my designated surrogate-healthcare agent-attorney-in-fact, from any and all liabilities in the performance of his/her duties pursuant to my wishes and declaration as stipulated in this Advance Directives, and mandate my estate and family to hold him/her harmless as well.

I hereby affix my signature on this declaration on my own free will and without any mental reservation, in the presence of the two witnesses, whose signatures are on the next and last page (9) of this declaration.

Signature: _____

Printed Name: _____

Witness: _____

Address: _____

City_____ State: _____

Phone: _____

Non-relative witness: _____

Address: _____

City: _____State: _____

Phone: _____

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----------(No entry below this line)----------

Note: You may amend and customize this Directive to suit your needs. Please Check online to see if your State requires Notary documentation