

# LIVING WILL

A living will is a document that allows you express your wishes for medical care in the event that you are unable to do so yourself. It covers three topics and allows you to have input on them.

1. When the death of the patient is approaching due to a terminal illness even after life sustaining treatment has been attempted.
2. When the patient is permanently unconscious – this is also referred to as a persistent vegetative state.
3. When a patient has arrived at an end-stage condition brought about by the advancement of an illness and results in complete physical dependence of the patient.

As the principal, you may complete the entire document to address all three conditions or only part of the document to address the situations you believe are most relevant to you.

## DESIGNATION OF AGENT

On this \_\_ day of \_\_\_\_\_, 20, I, \_\_\_\_\_ (hereinafter referred to as the "principal"), residing at \_\_\_\_\_ [Address], with the last four digits of my social security number being \_\_\_\_\_, and reachable at telephone number \_\_\_\_\_, hereby affirm my mental competence and physical well-being. I assert that I am making this declaration of my own volition, without any undue influence or coercion, and in full possession of my faculties.

I wish to unequivocally state that the directives outlined within this document shall be considered a definitive and formal expression of my preferences regarding my healthcare, medical treatment, and custodial arrangements. I affirm that these instructions, delineated below, are legally binding upon all concerned parties to the maximum extent permissible by law.

In the eventuality that this living will does not encompass a specific circumstance that may arise, I hereby designate \_\_\_\_\_ residing at \_\_\_\_\_ [Address], reachable at telephone number \_\_\_\_\_, as my agent (hereinafter referred to as the "attorney-in-fact"), empowered to act

on my behalf and in accordance with the provisions set forth in the document below. Should the primary agent aforementioned be unable or unwilling to fulfill their duties on my behalf, I appoint \_\_\_\_\_ of \_\_\_\_\_ [Address], reachable at telephone number \_\_\_\_\_, as my successor agent.

### **LIFE-SUSTAINING MEDICAL TREATMENT**

In some cases, people do not wish to have certain life sustaining treatments used under any circumstances. If there are certain treatments or procedures that you DO NOT want medical care professionals to use to sustain your life, please initial next to them below. Leave them blank if you wish for them to use all of the available options if the situation arises.

\_\_\_ Cardiopulmonary resuscitation with the aim of extending my life

\_\_\_ Using external life support devices such as respirators or ventilators perform regular bodily functions to extend my life

\_\_\_ Using external life support devices such as tube feeding or intravenous lines to deliver nutrition with the aim of extending my life

\_\_\_ Using blood or blood products to extend my life

\_\_\_ Using artificial dialysis machines to extend my life

\_\_\_ Using antibiotics and other medications to extend my life

\_\_\_ Other \_\_\_\_\_

I understand that if I DO NOT initial any treatment option above then I give my consent for that treatment to be used if it is required.

### **PREFERENCES FOR TERMINAL ILLNESS**

*(Initial only one of the options below. Leave blank if you have no preferences)*

In the event that my death is near due to a terminal illness even with the use of life-sustaining treatments, then:

\_\_\_ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. I also do not want additional fluids and or nutrition via medical means or tubes.

Or

\_\_\_\_\_ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

Or

\_\_\_\_\_ I wish for my health care providers to try and extend my life for as long as possible. Take advantage of all available treatment methods, procedures, and interventions that, under reasonable expectations, would prevent or delay my death. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

#### **PREFERENCES FOR PERSISTENT VEGITATIVE STATE**

*(Initial only one of the options below. Leave blank if you have no preferences)*

If it has been determined by my physicians that I am in a persistent vegetative state – I have no awareness of my surroundings or myself, I am not conscious, and I am unable to interact with others and there is no expectation due to prevailing medical techniques and treatment methods for me to regain consciousness – then:

\_\_\_\_\_ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. I also do not want additional fluids and or nutrition via medical means or tubes.

Or

\_\_\_\_\_ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

Or

\_\_\_\_\_ I wish for my health care providers to try and extend my life for as long as possible. Take advantage of all available treatment methods, procedures, and interventions that, under reasonable expectations, would prevent or delay my death. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

#### **PREFERENCES FOR END OF STAGE CONDITION**

*(Initial only one of the options below. Leave blank if you have no preferences)*

If it has been determined by my physicians that I am in an end-state conditions – an condition that current medicine has no cure for and which will progress until I die and has already created a significant loss of overall capacity and total physical dependency – then:

\_\_\_\_\_ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. I also do not want additional fluids and or nutrition via medical means or tubes.

Or

\_\_\_\_\_ I wish for my health care providers to ensure I remain comfortable and let a natural death occur. Refrain from any additional medical interventions to try to sustain or extend my life. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

Or

\_\_\_\_\_ I wish for my health care providers to try and extend my life for as long as possible. Take advantage of all available treatment methods, procedures, and interventions that, under reasonable expectations, would prevent or delay my death. If, during this time, I cannot take food or fluids by mouth, I wish to receive additional food and nutrition via tube or other medical means.

#### **COMFORT AND PAIN RELIEF**

*(Initial one option below to share your pain relief preferences. If you have none then leave this section blank)*

In line with my aforementioned decisions, I would like to take the following approach to my comfort and pain relief:

\_\_\_\_\_ I wish to utilize maximum pain relief medication and treatment options as long as it does not hasten my death.

\_\_\_\_\_ I wish to utilize maximum pain relief medication and treatment options even if it hastens my death.

\_\_\_\_\_ I wish to utilize maximum pain relief medication and treatment options even if it will result in addiction if I survive my current condition or an extended hospital stay.

\_\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_\_

#### **IN THE CASE OF PREGNANCY**

*(This is optional and should only be filled out by women of child-bearing age. If it is not applicable to you then leave blank).*

If it occurs that I am pregnant and need life-sustaining treatment, my preferences will change as follows:

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**END OF LIFE WISHES**

(this section should outline things such as hospice care, funeral arrangements, etc.)

When the time of my death draws near, it is important to me that my affairs are handled in the following manner:

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**SIGNATURE AND ACKNOWLEDGEMENT**

\_\_\_\_\_  
Signature of Declarant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

We, serving as witnesses, each declare that the declarant signed and executed this instrument in our presence. The declarant signed it in their right state of mind, to our knowledge is eighteen years of age or older, and willingly signed without undue pressure, influence, or duress. We each sign this power of attorney as witnesses at the request of the principal while the principal is present.

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**Witness's Signature**

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Address

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**Witness's Signature**

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Address

# Notary Acknowledgement

State of \_\_\_\_\_

County of \_\_\_\_\_

On \_\_\_\_\_, 20\_\_\_\_ before me, \_\_\_\_\_ (name and title of officer), personally appeared \_\_\_\_\_, who proved to me on the basis of satisfactory evidence to be the person(s) whose names are subscribed within the instrument and acknowledged to me that they executed the same in their authorized capacity(ies), and that by their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of \_\_\_\_\_ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature \_\_\_\_\_

(Seal)

Print Name \_\_\_\_\_