LIVING WILL: directive to physicians describing the patient's desire that life-sustaining procedures are not used to artificially prolong his life under described circumstances

LIVING WILL DIRECTIVE TO PHYSICIANS

Directive made and executed by _____[name], of _____[address], _____ County, _____[state], on _____[date].

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:

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death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. _____[If applicable, add: If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.]

4. I have been diagnosed and notified at least _____ days ago as having a terminal condition by _____, M.D., whose address is _____, and whose telephone number is _____. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I executed this directive.

5. This directive shall have no force or effect _____ years from the date filled in above.

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

7. I understand that I may revoke this directive at any time.

_____
[Signature]

ATTESTATION CLAUSE

On _____[date], _____[name], known to us to be the person whose signature appears at the end of the above directive, declared to us, the undersigned, that the above directive, consisting of _____ pages, including the page on which we have signed as witnesses, was _____[his or her] directive. _____[He or She] then signed the directive in our presence and, at _____[his or her] request, in _____[his or her] presence and in the presence of each other, we now sign our names as witnesses.

_____[Name] declarant has been personally known to us and we believe _____[him or her] to be of sound mind. We are not related to _____[name] by blood or marriage, nor would we be entitled to any part of _____[name's] estate on _____[name's] death, nor are we the attending physicians of _____[name] or an employee of the attending physician or a health facility in which _____[name] is a patient, or a patient in the health care facility in which _____[name] is a patient, or any person who has a claim against any part of the estate of the _____[name] on _____[name's] death.

_____, residing at
[Signature]
_____

_____
[Street, city, state]

_____, residing at
[Signature]
_____

_____
[Street, city, state]

_____, residing at
[Signature]
_____

_____
[Street, city, state]