

DIRECTIONS REGARDING MY CARE (LIVING WILL)

Name (Please Print)

If I, _____ should be in an end-stage condition or permanent vegetative state with no reasonable expectation of recovery, I direct my attending physician to withhold or withdraw treatment that merely **prolongs** my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.

These directions express my legal right to refuse treatment. Therefore I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes, and in so doing to be free of any legal liability for having followed my directions.

I DO NOT WANT: (PLEASE INITIAL)

Initial (CPR) Cardio-Pulmonary Resuscitation
Initial Mechanical respiration (Breathing by machine)
Initial Artificial feeding or fluids by tube

I WOULD LIKE TO BE AN ORGAN DONOR:

YES NO
(Please check one)

This Living Will Declaration expresses my personal preferences regarding my treatment according to my common-law and constitutional rights.

Signed: _____ Date: _____

I DO NOT WISH TO MAKE A DECLARATION AT THIS TIME.

SIGNED: _____ DATE: _____

Witness: _____ Witness: _____

MAY BE WITNESSED BY ANY COMPETENT ADULT (18 YEARS AND OLDER), ONE OF WHICH MAY BE A FAMILY RELATIVE.

DIRECTIONS IF I AM UNABLE TO COMMUNICATE MY WISHES (HEALTH CARE SURROGATE DESIGNATION)

Should I become unable to communicate my instructions as stated above, I designate the following person to act in my behalf:

Name: _____ Relationship: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

Signed: _____ Date: _____

I DO NOT WISH TO DESIGNATE A SURROGATE AT THIS TIME.

SIGNED: _____ DATE: _____

Witness: _____ Witness: _____

MAY BE WITNESSED BY ANY COMPETENT ADULT (18 YEARS AND OLDER), ONE OF WHICH MAY BE A FAMILY RELATIVE.

Keep a copy of this living will with your personal papers at home. Give copies to your physicians, family, and proxy. You will need to submit a copy upon each admission into the hospital.



ADVANCE DIRECTIVE / LIVING WILL
HEALTH CARE SURROGATE
WHITE - CHART YELLOW - SURROGATE
Form 909509 Rev 05/07/01



Patient ID Label

