

Living Will

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LIVING WILL (ADVANCE DIRECTIVE)

1. DECLARATION

1.1. I, [YOUR FULL NAME], of [ADDRESS], [CITY], [STATE] [ZIP], being of sound mind, voluntarily make this Living Will this [DATE]. This document expresses my wishes regarding medical treatment to be used if I become incapable of making or communicating decisions about my health care.

2. PURPOSE

2.1. This Living Will is made pursuant to applicable state law as an advance directive to guide physicians, family members, health care agents, and other caregivers in decisions about life-sustaining treatment.

3. DEFINITIONS

3.1. "Life-Sustaining Treatment" means any medical procedure or intervention that sustains, restores, or replaces a bodily function including, but not limited to, cardiopulmonary resuscitation (CPR), mechanical ventilation, dialysis, antibiotics, blood transfusions, and artificial nutrition and hydration.

3.2. "Terminal Condition" means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will result in death.

3.3. "Permanent Unconsciousness" means a condition in which consciousness cannot be regained as determined by my treating physician and any consulting physicians.

4. APPOINTMENT OF HEALTH CARE AGENT (OPTIONAL)

4.1. I hereby designate [HEALTH CARE AGENT NAME], of [AGENT ADDRESS], [CITY], [STATE] [ZIP], telephone [AGENT PHONE], as my health care agent (also referred to as health care proxy) to make health care decisions on my behalf if I am unable to do so.

4.2. If the person named above is unable, unwilling, or unavailable to act as my agent, I designate [ALTERNATE AGENT NAME], of [ALTERNATE AGENT ADDRESS], [CITY], [STATE] [ZIP], telephone [ALTERNATE AGENT PHONE], as alternate agent.

4.3. My agent shall follow the instructions contained in this Living Will and act in accordance with my known wishes. If my wishes are unknown, my agent shall act in my best interest.

5. GENERAL STATEMENT OF DESIRES

5.1. If I have a terminal condition or am permanently unconscious, I direct that the following provisions be carried out according to the specifics below and applicable law.

6. LIFE-SUSTAINING TREATMENT: CONSENT OR REFUSAL

6.1. I direct that: (check one)

A. I DO WANT all generally accepted life-sustaining treatments, including cardiopulmonary resuscitation (CPR), mechanical ventilation, dialysis, antibiotics, and artificial nutrition and hydration, subject to the judgment of my treating physician as to effectiveness and burden.

B. I DO NOT WANT life-sustaining treatments if they would only prolong the dying process, and I want treatment limited to comfort measures to keep me comfortable and relieve pain.

C. I WANT the following limitations or special instructions regarding life-sustaining treatment: [SPECIFY LIMITATIONS OR INSTRUCTIONS].

7. ARTIFICIAL NUTRITION AND HYDRATION

7.1. I direct that: (check one)

A. Artificial nutrition and hydration (tube feeding or IV fluids) be provided when medically appropriate

as determined by my physician.

B. Artificial nutrition and hydration be withheld or withdrawn in circumstances where it only prolongs the dying process or when my condition is irreversible, and I prefer comfort care only.

C. Other instructions regarding artificial nutrition and hydration: [SPECIFY INSTRUCTIONS].

8. CARDIOPULMONARY RESUSCITATION (CPR)

8.1. I direct that: (check one)

A. If my heart stops or I stop breathing, I DO WANT CPR and all emergency measures that may restart my breathing or heartbeat.

B. If my heart stops or I stop breathing, I DO NOT WANT CPR or other resuscitative measures.

C. Other instructions regarding CPR: [SPECIFY INSTRUCTIONS].

9. PAIN MANAGEMENT AND PALLIATIVE CARE

9.1. Regardless of other directives, I request that treatment to relieve pain and discomfort be provided at all times, even if such treatment may hasten the moment of death as an unintended effect.

10. ORGAN DONATION (OPTIONAL)

10.1. Upon my death I direct: (check one)

A. To donate any organs or tissues for transplantation, therapy, research, or education as permitted by law.

B. To donate only the following organs or tissues: [SPECIFY].

C. I DO NOT wish to donate organs or tissues.

10.2. Additional instructions regarding donation: [ORGAN DONATION INSTRUCTIONS].

11. PREGNANCY

11.1. If I am pregnant at the time of incapacity, my pregnancy wishes are: [SPECIFY WISHES REGARDING PREGNANCY]. If no instruction is provided, decisions shall be made in accordance with applicable law and the best medical judgment of my health care agent and physicians.

12. EFFECTIVENESS AND DURATION

12.1. This Living Will is effective when my attending physician determines that I lack the capacity to make health care decisions for myself.

12.2. This Living Will shall remain in effect until revoked by me in the manner described in Section 13 or until my death.

13. REVOCATION

13.1. I may revoke this Living Will at any time and in any manner that communicates my intent to revoke, including oral statements to my attending physician or agent, or by physically tearing up or destroying this document.

13.2. Any subsequent oral or written statement by me that is inconsistent with this Living Will shall be treated as a revocation of inconsistent provisions.

14. RELIANCE AND IMMUNITY

14.1. Any physician, health care provider, hospital, nursing home, or other person acting in good faith and in substantial compliance with this Living Will shall not be subject to civil or criminal liability or professional disciplinary action for complying with this Living Will.

15. NOMINATION OF GUARDIAN (OPTIONAL)

15.1. In the event a guardian of my person is required, I nominate [GUARDIAN NAME], of [GUARDIAN ADDRESS], [CITY], [STATE] [ZIP], to serve as guardian. If that person is unable or unwilling to serve, I nominate [ALTERNATE GUARDIAN NAME], of [ALTERNATE GUARDIAN ADDRESS], [CITY], [STATE]

[ZIP].

16. INSTRUCTION TO FAMILY AND CAREGIVERS

16.1. I request that my family and caregivers follow the instructions contained in this Living Will, discuss any unclear matters with my health care agent (if appointed) and my attending physician, and act in accordance with my expressed wishes and best interests.

17. SEVERABILITY

17.1. If any provision of this Living Will is held invalid or unenforceable, the remaining provisions shall continue in full force and effect.

18. GOVERNING LAW

18.1. This Living Will shall be governed by the laws of the State of [STATE], without regard to conflict of law principles.

19. SIGNATURE

I SIGNED this Living Will on [DATE], at [CITY], [STATE]. I declare that I am emotionally and mentally competent to make this Living Will and that I understand the nature and effect of this document.

Declarant:

[YOUR FULL NAME]

Address: [ADDRESS], [CITY], [STATE] [ZIP]

Date of Birth: [DATE OF BIRTH]

20. WITNESS ATTESTATION

I declare under penalty of perjury that the person who signed or acknowledged this Living Will is personally known to me, that they are generally of sound mind, and that they appeared to sign voluntarily. I am not: (a) the person appointed as health care agent in this document; (b) a person who is entitled to any portion of the estate of the declarant as designated in a will or other instrument; nor (c) the declarant's attending physician. (Check local requirements; some states limit who may serve as witness.)

Witness 1:

[WITNESS 1 NAME]

Address: [WITNESS 1 ADDRESS]

Date: [DATE]

Witness 2:

[WITNESS 2 NAME]

Address: [WITNESS 2 ADDRESS]

Date: [DATE]

21. NOTARY ACKNOWLEDGMENT (OPTIONAL / AS REQUIRED BY STATE LAW)

State of [STATE]

County of [COUNTY]

On this [DATE], before me, [NOTARY NAME], personally appeared [YOUR FULL NAME], known to me (or satisfactorily proven) to be the person whose name is subscribed to this instrument, and acknowledged that they executed the same for the purposes therein contained.

Notary Public Signature

[NOTARY NAME]

My commission expires: [NOTARY EXPIRATION]

Commission Number: [NOTARY COMMISSION NUMBER]

22. INSTRUCTIONS FOR USE

22.1. Complete all requested information and strike any options that do not apply. Keep original signed copies accessible to your health care agent (if appointed), family members, and treating physicians. Provide copies to your primary care physician, local hospital, and other caregivers.

22.2. This Living Will is a legal document. State law on advance directives varies. Consult state-specific requirements for witness, notarization, language, and form. Consider consulting an attorney to ensure compliance with your state's laws and to address any complex medical or legal circumstances.

23. OPTIONAL ADDITIONAL PROVISIONS

23.1. Specific medical treatments I accept or refuse: [LIST SPECIFIC TREATMENTS, MEDICATIONS, OR CIRCUMSTANCES].

23.2. Personal values or beliefs that should guide decisions: [DESCRIBE PERSONAL VALUES, RELIGIOUS OR MORAL CONSIDERATIONS].

END OF LIVING WILL

(KEEP THIS DOCUMENT WITH YOUR IMPORTANT PAPERS AND PROVIDE COPIES TO YOUR PHYSICIAN, AGENT, AND FAMILY MEMBERS.)

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