LIVING WILL

Statutory Short Form

This living will is effective only while I am unable to make or communicate my health care decisions.

(Some general statements concerning your health care options are outlined below. If you agree with one of the
statements, you should initial that statement. Read all of these statements carefully before you initial your selection.
You can also write your own statement concerning life-sustaining treatment and other matters relating to your health
care. You may initial any combination of paragraphs 1, 2, 3, and 4, but if you initial paragraph 5 the others should not be initialed.)

1. ______ If I have a terminal condition I do not want my life to be prolonged and I do not want life-sustaining
treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

2. ______ If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors
reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide
care that would keep me comfortable, but I do not want the following:

(a) ______ Cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial
breathing.

(b) ______ Artificially administered food and fluids.

(c) ______ To be taken to a hospital if at all avoidable.

3. ______ Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment
withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the
continued application of life-sustaining treatment.

4. ______ Notwithstanding my other directions, I do want the use of all medical care necessary to treat my condition
until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am
in a persistent vegetative state.

5. ______ I want my life to be prolonged to the greatest extent possible.

Other or Additional Statements of Desires

I have _____ I have not _____ attached additional directions or limitations to this Living Will to be honored in the
absence of my being able to give health care directives.

Signature or Mark of Person making Living Will

______________________________
Date: _________________________

Verification

I affirm that: (1) I was present when this living will was dated and signed or marked or (2) that the person making this
living will directly indicated to me that the living will expressed that person’s wishes and that the person intended to
adopt it at that time. I affirm further that the person making this health care living will appeared to be of sound mind
and free from duress at the time of its execution.

I certify that I have not been designated to make medical decisions for the person who signed this living will and am
not directly involved with providing health care to that person. If this Living Will is witnessed only by me, I certify that
I am not related to the person making this Living Will by blood, marriage, or adoption and am not entitled to any part
of that person’s estate.

Witness: _________________________ Address: _________________________

Witness: _________________________ Address: _________________________

Date: _________________________ Date: _________________________