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Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.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