LIVING WILL

To my family, my friends, my physician and all others who may be interested:

I,_____, request that I be fully informed of my medical condition. Whenever possible, I want to participate in decisions regarding my medical treatment, including whether any measure should be taken to prolong my life. If my physicians determine I do not have capacity to make health care decisions, this directive should be used to ascertain my decision.

In the event my physicians determine, to a reasonable degree of medical certainty, that I am in a terminal condition that will inevitably lead to my death, or that I am permanently unconscious, I direct that I not be given medical treatment where it will serve only to prolong my dying or continue my unconscious state. In such an event, I do want those measures that will keep me comfortable and relieve pain, even if they will render me unconscious or hasten my death.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

☐ I do	☐ I do not	want cardiac resuscitation.
☐ I do	☐ I do not	want mechanical respiration.
☐ I do	☐ I do not	want artificially provided nutrition (food).
☐ I do	☐ I do not	want artificially provided hydration (water).
☐ I do	☐ I do not	want blood or blood products.
☐ I do	☐ I do not	want any form of surgery or invasive diagnostic tests.
☐ I do	☐ I do not	want kidney dialysis.
☐ I do	☐ I do not	want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment. I also realize I may change my opinion at any time and will notify my health care provider of this change.

Additionally, in the event of my death, I would like to make it known that:

☐ I do	☐ I do not	want to donate my body to medical science.
☐ I do	☐ I do not	want to donate my organs and tissues. Noting the following limitations, if any:

_____

This directive was made after careful consideration and is in accordance with my strong convictions and beliefs. I want the directions followed to the extent permitted by law. I release from legal liability all persons and entities involved in carrying out the directions and direct my legal representative(s) to honor this release.

Signature:_____ Date:_____
Print Name:_____

Witness:_____ Date:_____
Print Name:_____

Witness:_____ Date:_____
Print Name:_____

THIS LIVING WILL FORM IS PROVIDED AS A COURTESY TO OUR PATIENTS, BUT SHOULD NOT TAKE THE PLACE OF CONSULTING YOUR ATTORNEY OR FAMILY PHYSICIAN.

01/01/2020