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LIVING WILL DECLARATION FORM

Declaration made this _____ day of _____, _____.
I,_____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am both mentally and physically incapacitated

_____ and I have a terminal condition
(INITIAL)
or _____ and I have an end-state condition
(INITIAL)
or _____ and I am in a persistent vegetative state
(INITIAL)

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____
Address: _____
_____
Phone: _____

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

ADDITIONAL INSTRUCTIONS (optional): _____
_____
_____

Signed: _____

Witness: _____ Witness: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____

INSTRUCTIONS FOR LIVING WILL DECLARATION FORM

1. Insert the date and your full name in the blanks provided at the top of the form.

2. Place your initials next to the condition(s) you want to exist before the terms of your living will are carried out.

3. In the area for designation of a surrogate you can name someone to carry out the terms of your living will. You may also designate someone to make your treatment decisions if a situation not contemplated by your living will should arise. If you do this you should indicate in the "Additional Instructions" section how much authority this person may have beyond carrying out the terms of this document. You are not restricted as to whom you may name, but two things are very important. First, the person whom you name should be readily available to make your decisions and should be aware of what your wishes are. Secondly, do not list more than one person unless you clearly indicate who has priority in the decision-making process. You do not want to have a disagreement between two decision makers. If you do not name a surrogate to carry out the terms of the living will, your health care provider may do so.

4. Under "Additional Instructions," between the body of the living will and your signature lines, you may indicate any specific wishes. If you add language in this area, have someone else read it and tell you what he/she thinks it means. It is very important that any language you add here be clear and concise and that it accurately reflects your wishes. Before filling in this section you may wish to discuss the terms with your personal attorney. If this living will revokes a previous living will, add in the additional instructions area: "This document revokes my living will signed on _____ and supersedes any previous declarations made by me." If you do not use this space, place an "X" through the space so that someone cannot later add information.

5. Sign the living will in the presence of two witnesses, one who is not a spouse or blood relative. Each witness should affix his signature. By affixing his signature, the witness is stating that you understood the contents of the living will, were functionally competent to sign same and that the signature is, in fact, yours. If you are physically unable to sign the living will, you may make your intentions to sign known orally to the witnesses. One of the witnesses may then subscribe your signature thus:

   John Doe (Declarant)

   _____

   by Jane Smith (Witness)

6. Keep the original will in a safe place and give copies to a close relative, friend, attorney, spiritual advisor, and most importantly, to your physician and to your health care facility.

THESE INSTRUCTIONS ARE FOR GENERAL INFORMATION ONLY.

HEALTH CARE SURROGATE DESIGNATION FORM

Name _____
LAST FIRST MIDDLE

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____
Address: _____
Phone Number: _____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate surrogate:

Name: _____
Address: _____
Phone Number: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or from a health care facility.

Additional instructions (optional):_____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: _____
Address: _____
Name: _____
Address:_____
Signed:_____ Date: _____
Witness: 1._____ Witness: 2._____

- Witnesses cannot be designated surrogate or alternate. One of the witnesses cannot be a spouse or blood relative.

ACCEPTANCE OF SURROGATE DESIGNATION

I, _____, do hereby accept responsibility to act as health care surrogate for _____ should he/she become incapacitated.

Current Address: _____
Signed: _____ Date:_____

INSTRUCTIONS FOR SURROGATE DESIGNATION FORM

1. Fill in your complete name in the blank provided on top of the form.

2. Put the name, address and phone number of the person you are designating to serve as your health care surrogate in the second series of blanks.

3. Put the name, address and phone number of the person you are designating to serve as your alternate health care surrogate in the third series of blanks. If you do not wish to choose an alternate health care surrogate, you may leave this area open and this will not affect the rest of the document.

4. Sign this document in front of two witnesses. The party designated as a surrogate or alternate cannot be the witness and at least one person who acts as a witness shall be neither your spouse nor blood relative.

5. Give a copy of this designation form to all of your health care providers. Keep the original in a safe place.

6. This designation can be voided by designating a new health care surrogate or by clearly revoking it. However, the new health care surrogate designation or the revocation may not become effective unless communicated to all of your health care providers.

THESE INSTRUCTIONS ARE FOR GENERAL INFORMATION ONLY.