LIVING WILL (HEALTH CARE DIRECTIVE)

This form was completed and signed on _____ (mm/dd/yyyy).

I, _____, with a street address of _____, City of _____, County of _____, State of _____, with the last four (4) digits of my social security number (SSN) being XXXX - XX - _____ (Hereinafter referred to as the 'Principal') desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

A. LIFE SUPPORT

I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

_____ ☐ - Chronic coma or persistent vegetative state

_____ ☐ - no longer able to communicate my needs

_____ ☐ - no longer able to recognize family or friends

_____ ☐ - total dependence on others for daily care

_____ ☐ - Other: _____.

Initial and check only one:

_____ ☐ - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).

_____ ☐ - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

B. CERTAIN LIFE-SUSTAINING TREATMENT: (You do not have to initial and check any of the options below if you do not wish to)

Some people do not wish to have certain life sustaining treatments under any circumstance, even if recovery is a possibility. Check treatments below, if any, that you do not wish to have under any circumstances:

_____ ☐ - Cardiopulmonary Resuscitation (CPR)

_____ ☐ - Ventilation (breathing machine)

_____ ☐ - Feeding tube

_____ ☐ - Dialysis

_____ ☐ - Other: _____.

C. END OF LIFE WISHES (hospice care, funeral arrangements, etc.):

When I am near death, it is important to me that:

I have signed this document on _____ (mm/dd/yyyy).

Principal's Signature Printed Name

WITNESS ACKNOWLEDGMENT

On the date set forth above, I hereby state as follows:

The above named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am at least 18 years old and not related to him/her by blood, marriage or adoption. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

WITNESS 1

Signature Print Name

Address Phone Number

WITNESS 2

Signature Print Name

Address Phone Number

NOTARY ACKNOWLEDGMENT

State of _____ }

County of _____ }

I, the undersigned authority in and for said County in said State, hereby certify that the Principal _____, whose name is signed above in this living will, and who is known to me, acknowledged before me on this day that, being informed of the contents of the said document, (s)he executed the same voluntarily on the date this living will bears.

Given under my hand this _____ (mm/dd/yyyy).

Notary Public Signature: _____

Printed Name: _____

My commission expires: _____ (mm/dd/yyyy)

(Notary Seal)