LOUISIANA LIVING WILL DECLARATION

Declaration made this _____ day of _____, 20__.

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible condition by two physicians who have personally examined me, one of who shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized, and where the application of life-sustaining procedures would serve only to prolong artificially the dying process, I direct (initial one only):

_____ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

_____ That all life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct 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.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

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

Signed: _____

Print Name: _____

City, Parish and State of Residence_____

_____

WITNESSES

I declare that the person who signed this document is personally known to me, and that he or she appears to be of sound mind. I am at least 18 years of age and am not related to the person who signed this document by blood or marriage, or entitled to any portion of his/her estate under any will or by operation of law.

1. _____
Witness

_____
Address

_____
City State/Zip

2. _____
Witness

_____
Address

_____
City State/Zip

Wallet Card

It is essential that your health care provider know that you have executed an advance directive. Your treating physicians should be given a copy of the documents.

The wallet card is one way to do this. Fill out the card, sign, and date it. Then cut it out and carry it with you at all times. It may be helpful to laminate this wallet card.

Notice to Health Care Providers

☐ *I have executed a **Living Will***
☐ *I have executed a **Health Care Power of Attorney** and appointed:*

_____ *(Agent's Name)*

_____ *(Agent's Address)*

Phone: _(___)_____ (day) _(___)_____(eve.)
As my agent to make health and personal care decisions for me if I am unable to do so. He/she has a copy of my complete health care power of attorney.

_____ _____
(Date) *(Your Printed Name)*

_____
(Signature)