# Living Will

I, _____ am of sound mind, and I voluntarily make this declaration.

If I become terminally ill or permanently unconscious as determined by my doctor and at least one other doctor, and if I am unable to participate in decisions regarding my medical care, I intend this declaration to be honored as the expression of my legal right to authorize or refuse medical treatment.

My desires concerning medical treatment are -

(attach additional sheets if you wish)

My family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for following my wishes as expressed in this declaration.

I may change my mind at any time by communicating in any manner that this declaration does not reflect my wishes.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

Dated: _____ Signed: _____

(Your signature)

_____

(Your address)

**STATEMENT OF WITNESSES**

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____

(Print Name) (Signature of Witness)

_____

(Address)

_____ _____

(Print Name) (Signature of Witness)

_____

(Address)