**LIVING WILL FOR HEALTH CARE**

Date of Directive: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person executing Directive: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of person executing Directive: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

**A Living Will**

**A Directive to Withhold or to Provide Treatment**

1. I willfully and voluntarily make known my desire that my life *shall not* be prolonged artificially under the circumstances set forth below. This Directive shall be effective only if I am unable to communicate my instructions and:

a. I have an incurable or irreversible injury, disease, illness or condition, and a medical doctor who has examined me has certified:

1. That such injury, disease, illness or condition is terminal; and

2. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and

3. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

OR

b. I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following marked expression of my intent be followed and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

**Check one box and initial the line after such box**: 

I direct that all medical treatment, care, and procedures necessary to restore my health and sustain my life be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

OR

I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from me if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows: (If none of the following boxes are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be administered.) Check one box and initial the line after such box: 

A. Only hydration of any nature, whether artificial or non-artificial, shall be administered.

B. Only nutrition, of any nature, whether artificial or non-artificial, shall be administered. 

C. Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

OR 

I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration.

2. If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.

3. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this

Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

4. Check one box and initial the line after such box:

I have discussed these decisions with my physician and have also completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with, this Directive. I hereby approve of those orders and incorporate them herein as if fully set forth.

OR

I have not completed a Physician Orders for Scope of Treatment (POST) form. If a POST form is later signed by my physician, then this living will shall be deemed modified to be compatible with the terms of the POST form.

***I sign my name to this Statutory Form Living Will on the date set forth at the beginning of this Form at:***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_

***(You must date and sign this Living Will for Health Care)***