NEW YORK STATE LIVING WILL & HEALTH CARE PROXY

1. I, _____, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my Medical care. I am in full possession of my faculties, and after long and careful consideration, make this my declaration. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below.

2. I, _____, being of sound mind, hereby appoint _____, as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions. Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely.

Name: _____
Address:_____
Phone number: _____

This individual appointed as my health care agent shall make all health care decision for me in conformity with the guidelines I have expressed in this document. I direct my agent to make health care decisions in accordance with my wishes and instructions as stated within this document, or as otherwise known to him or her. I also direct my agent to abide by any limitations on his or her authority as stated within this document, or as other wise known to him or her.

3. ALTERNATE/SUBSTITUTE AGENT: If the person that I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint: _____, as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise, (with the same powers that I have enumerated herein). Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely.

Name: _____
Address:_____
Phone number: _____

This individual appointed as my alternate/substitute health care agent, should they become my actual health care agent, shall make all health care decision for me in conformity with the guidelines I have expressed in this document. I direct my agent to make health care decisions in accordance with my wishes and instructions as stated within this document, or as otherwise known to him or her. I also direct my agent to abide by any limitations on his or her authority as stated within this document, or as other wise known to him or her.

4. I direct my attending physician, or other medical personnel, to withhold or withdraw treatment that serves only to prolong the process of my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery *(i.e. if I am in a terminal condition, permanently unconscious, or if I am conscious by have irreversible brain damage and will never regain the ability to make decisions and express my wishes).* .

I do not wish to be kept alive by various measures if there is no reasonable expectation of my being able to enjoy a meaningful quality of life. This proxy shall apply if I have an illness, disease or injury, or experience extreme mental deterioration, and if doctors selected by me or by my family determine that there is not reasonable expectation that I will recover to a sufficient extent to enable me to enjoy a meaningful quality of life. While it is obviously impossible to foresee all of the circumstances in which I would feel that this direction is applicable, but without in any way limiting the general scope of the foregoing direction, I would certainly include the following instructions to apply if I am: a) In a terminal condition; b) permanently unconscious, in a coma for a sufficient time period; c) conscious but have irreversible brain damage and will never (or it is extremely unlikely) regain the ability to make decisions and express my wishes; d) suffering such brain, heart or other physical damage, that it is unlikely that I would be able to perform enough bodily functions to render my life bearable and enable me to have some enjoyment out of life; or e) losing my mental faculties to the extend of being unable to recognize my family and friends or my surroundings, or to understand where I am and what I am doing, or to communicate coherently, and there is no reasonable expectation that this situation will be reversed.

5. I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment. While I understand that I am not legally required to be specific about future treatments, if I am in the condition(s) described above, I feel especially strong about the following forms of treatment. I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions:

I do / do not want cardiac resuscitation
I do / do want mechanical respiration/respiratory support
I do / do want tube feedings/artificially administered nutrition and hydration
I do / do not want antibiotics
I do / do not want surgery
I do / do not want maximum pain relief

6. I understand that unless I revoke it, this living will and health care proxy will remain in effect indefinitely.

THESE DIRECTIONS EXPRESS MY LEGAL RIGHT TO REFUSE TREATMENT, UNDER THE LAWS OF NEW YORK STATE. UNLESS I HAVE REVOKED THIS INISTRUMENT OR OTHERWISE CLEARLY AND EXPLICITLY INDICATED THAT I HAVE CHANGED MY MIND, IT IS MY UNEQUIVOCAL INTENT THAT MY INSTRUCTIONS AS SET FORTH IN THIS DICUMENT BE FAITHFULLY CARRIED OUT.

DATED: _____, 20___ **_____**

Organ and/or Tissue Donation:

I hereby make an anatomical gift, to be effective upon my death, of: *(please initial which apply)*

Any needed organs and/or tissues: _____

The following organs and/or tissues: _____

_____

_____

Limitations: _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise, authorized by law, to consent to a donation on your behalf.

DATED: _____, 20____ **_____**

STATEMENT BY WITNESSES *(AGE 18 OR OLDER)*: We, severally, declare that the person who signed this document is personally known to me and appears to be of sound mind and acting on his or her own free will. He or she signed this document in my presence.

DATED:_____, 20____ **DATED: _____, 20____**

Witness 1 **Witness 2**

_____ _____

Severally sworn to before me this
_____ day of _____, 20__.

_____
Notary Public – State of New York

KEEP THIS SIGNED ORIGINAL WITH YOUR PERSONAL PAPERS AT HOME. GIVE COPIES OF THE SIGNED ORIGINAL TO YOUR DOCTOR, FAMILY, LAWYER, AND OTHERS WHO MIGHT BE INVOLVED IN YOUR CARE.