# LIVING WILL DECLARATION



*CL0002*

**INSTRUCTIONS**
***Consult this column for guidance.***

***This declaration sets forth your directions regarding medical treatment.***

To My Family, Doctors, and All Those Concerned with My Care:
I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care.

If my death is near and cannot be avoided, or if I become comatose and lose the ability to interact with others and have no reasonable chance of regaining this ability, or if my suffering is intense and irreversible due to my mental or physical condition, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.

***You have the right to refuse treatment you do not want, and you may request the care you do want.***

These directions express my legal right to refuse treatment. Therefore I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes, and in so doing to be free of any legal liability for having followed my directions.

***You may list specific treatment you do not want. For example"***

- ***Cardiac resuscitation (CPR)***
- ***Mechanical respiration***
- ***Feeding tubes***
- ***Intravenous fluids/hydration***

***Otherwise, your general statement, top right, will stand for your wishes.***

I especially do not want: _____

_____

_____

_____

_____

_____

_____

_____

***You may want to add instructions or care you do want – for example, pain medication; or that you prefer to die at home if possible.***

Other instructions/comments: _____

_____

_____

_____

_____

***If you want, you can name someone to see that your wishes are carried out, but you do not have to do this.***

**PROXY DESIGNATION CLAUSE:** In order to carry out my instructions as stated above and to interpret them, I designate the following person to act on my behalf:

Name: _____

Address: _____

Home Telephone # _____ Work Telephone # _____

If the person I have named above is unable to act on my behalf, I authorize the following person to do so:

Name: _____

Address: _____

Home Telephone # _____ Work Telephone # _____

*CL0002*

***Organ/Tissue Donation can save lives, preserve sight and improve function. You may limit your anatomical gift (cornea, kidney, etc.) or potentially help numerous people.***

**ORGAN DONATION:** I hereby make this anatomical gift to take effect upon my death:

☐ I give ☐ any needed organs or parts

☐ the following organs or parts _____

_____

_____

to be used for transplantation or otherwise for the direct care and treatment of another person.

☐ I do not give permission for organ donation.

Signed: _____

***The autopsy is valuable tool for expanding our understanding of disease, its diagnosis and treatment.***

**AUTOPSY CONSENT:**

☐ I agree to the performance of an autopsy in the event that my physician(s) feel that it would further medical knowledge or improve medical care.

Limitation(s) (if any) _____

_____

☐ I do not give permission for an autopsy.

Signed: _____

***Organ donation and autopsy are surgical procedures which do not result in unusual disfigurement of the body.***

***Sign and date here in the presence of two adult witnesses, who should also sign, or before a Notary Public. Neither adult witness can be your designated health care proxy or alternate proxy.***

***Keep the signed original with your personal papers at home. Give signed copies to doctors, family, proxy, and to you hospital should you require medical treatment.***

Signed: _____ Date: _____

Witness: _____ Witness: _____

Date:_____ Time:_____AM/PM Date:_____ Time:_____AM/PM

Address: _____ Address: _____

_____ _____

**Reviewed on:** It is recommended that you review your Declaration annually, initial and date it to show it still expresses your intent.

_____ _____
DATE INITIAL

_____ _____
DATE INITIAL

_____ _____
DATE INITIAL

_____ _____
DATE INITIAL

*Adapted with permission of Choice in Dying, formerly Concern for Dying / Society for the Right to Die, 250 West 57th St. / New York, NY 10101*