LIVING WILL

I, _____, born _____, of _____, in _____ County, State of _____, am an adult of sound mind. I sign this document of my own free will, and no one has pressured me to sign it. It tells my doctors, my family and anyone who decides for me what care I want if I can no longer make or communicate my own decisions. I cancel every earlier living will and health care directive.

Before you use this form: states differ on who may witness it, whether a notary is needed, what happens during pregnancy, and whether their own form is expected. Texas calls this a Directive to Physicians and California an Advance Health Care Directive. Check your state's rules, or use the LawVault builder, which applies them for you.

1. WORDS USED IN THIS DOCUMENT

"Life-sustaining treatment" means treatment that keeps me alive or puts off my death but will not cure my underlying condition, such as CPR, a breathing machine, dialysis, or drugs to keep my heart going. It does not include care given only for comfort or pain relief.

"Artificial nutrition and hydration" means food or fluids given through a tube or a needle. It does not include food or drink offered by mouth.

A "terminal condition" is an incurable condition expected to cause my death soon, even with treatment. "Permanently unconscious" means I have lost all awareness and will not regain it. An "end-stage condition" is a severe, lasting decline in which I cannot decide for myself and depend on others for nearly all of my care.

2. WHEN THIS DOCUMENT APPLIES

My instructions apply only when I cannot make or communicate my own decisions and my attending physician and one other physician who has examined me agree, in my medical record, that I have one of the conditions below with no reasonable chance of recovery. While I can decide for myself, I do.

3. MY CHOICES ABOUT LIFE-SUSTAINING TREATMENT

Initial one choice for each condition. (A) Do not use treatment to prolong my life; keep me comfortable. (B) Try treatment for up to _____ days, then stop if I am not getting better. (C) Use treatment to prolong my life as long as medically reasonable.

If I have a terminal condition: ____ A ____ B ____ C

If I am permanently unconscious: ____ A ____ B ____ C

If I have an end-stage condition: ____ A ____ B ____ C

Whenever I have chosen A or B, I specifically do not want (initial any): ____ CPR ____ a breathing machine ____ dialysis ____ antibiotics (except for comfort) ____ transfusions ____ major surgery ____ intensive care.

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4. ARTIFICIAL NUTRITION AND HYDRATION

INITIAL ONE. IF ANY CONDITION ABOVE APPLIES TO ME: ____ I DO NOT WANT ARTIFICIAL NUTRITION OR HYDRATION, AND IF STARTED, I WANT IT STOPPED. ____ I WANT A TRIAL FOR UP TO _____ DAYS, THEN STOPPED IF I AM NOT GETTING BETTER. ____ I WANT IT GIVEN TO ME. I UNDERSTAND THAT STOPPING IT MAY LEAD TO MY DEATH.

I want to be offered food and drink by mouth whenever I can safely swallow.

5. PAIN RELIEF AND COMFORT

Comfort care continues at all times. Initial one: ____ Give me enough medicine to control my pain, even if it makes me drowsy or may shorten my life. ____ Control my pain but keep me as alert as possible.

Other wishes (hospice, where I would like to be, spiritual or personal wishes):

_____

6. IF I AM PREGNANT

If I am pregnant when this document would apply (initial one): ____ follow my instructions as written, as far as the law allows ____ continue treatment if the fetus could develop to live birth ____ continue treatment for the rest of the pregnancy. I understand that the law of my state may limit this choice.

7. ORGAN AND TISSUE DONATION

Initial one: ____ At my death, I give any organs or tissues that can be used. ____ I give only these parts: _____. ____ I do not want to donate. ____ I make no decision here. Allowed purposes (initial any): ____ transplant ____ therapy ____ research ____ education.

8. HEALTH CARE AGENT (OPTIONAL)

I appoint _____, of _____, phone _____, as my health care agent. If my agent cannot act, I appoint _____, phone _____, as my backup agent. My agent may make any health care decision I could make, in line with this document and my known wishes, starting when my doctor finds that I cannot decide for myself. Leave this section blank if you are not naming an agent.

9. HIPAA AUTHORIZATION

I authorize my health care providers and health plans to disclose my health information, including my complete medical records, to my agent and to _____, so they can help make and carry out decisions about my care. This authorization takes effect now and ends two years after my death. I may revoke it in writing at any time, except where a provider has already acted on it. My treatment will not be conditioned on signing it, and information shared under it may be shared again and lose federal privacy protection.

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10. GENERAL TERMS

I may revoke this document at any time by destroying it, signing a dated revocation, telling my doctor, or signing a new directive. A copy has the same effect as the original. This document is not a POLST or do-not-resuscitate order; emergency crews may need one of those, signed by my clinician. If part of this document is invalid, the rest still applies.

My primary doctor: _____, phone _____. People to tell before treatment is stopped: _____.

SIGNATURES

Declarant

Signature: _____ Date: _____

Printed Name: _____

WITNESSES

Each witness states: I am an adult. I saw the declarant sign, or the declarant told me the signature is theirs. The declarant appears to be of sound mind and free of pressure. I am not the declarant's agent, not related to the declarant by blood, marriage or adoption, not entitled to any part of the declarant's estate, not financially responsible for the declarant's care, and not the declarant's doctor or an employee of a provider or facility caring for the declarant.

Witness 1: _____ Printed name: _____ Date: _____

Witness 2: _____ Printed name: _____ Date: _____

NOTARY ACKNOWLEDGMENT (IF YOUR STATE USES ONE)

State of _____, County of _____. On _____, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identity to be the person who signed this document, and acknowledged signing it voluntarily.

Notary Public: _____ My commission expires: _____ (Seal)

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