**LIVING WILL**

**State:** [STATE]

1. I, with the mailing address of [ADDRESS] desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

**Preference in Case of Terminal Condition** [INSERT IF APPLICABLE]

1. If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

[Keep me comfortable and allow natural death to occur. I do not want to receive nutrition and fluids by tube or other medical means. I do not want any medical interventions used to try and extend my life.] **OR**

[Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tubes or other medical means.] **OR**

[Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tubes or other medical means.]

**Preference in Case of Persistent Vegetative State** [INSERT IF APPLICABLE]

1. If my doctors certify that I am in persistent vegetative state, that is, if I am not conscious and am not aware of myself or my surroundings or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

[Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try and extend my life. I do not want to receive nutrition and fluids by tube or other medical means.] **OR**

[Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tubes or other medical means.] **OR**

[Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tubes or other medical means.]

**Preference in Case of End-Stage Condition** [INSERT IF APPLICABLE]

1. If my doctors certify that I am in end-stage condition, that is, an incurable condition that will continue in its course until my death, and that has already resulted in loss of capacity and complete physical dependency:

[Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try and extend my life. I do not want to receive nutrition and fluids by tube or other medical means.] **OR**

[Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tubes or other medical means.] **OR**

[Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tubes or other medical means.]

**Pain Relief**

1. No matter what my condition, please give to me the necessary medicine or other treatment I need to relieve pain.

**In Case of Pregnancy** [OPTIONAL FOR WOMEN OF CHILD-BEARING YEARS]

1. If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows: [INSERT INFORMATION].

**Effect of Stated Preferences**

1. [I realize I cannot foresee everything that might happen after I am no longer capable of making my own decisions. My stated preferences above are meant to guide whoever is making decisions on my behalf and my health care providers; however, I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.] **OR**

[I realize that I cannot foresee everything that might happen after I am no longer capable of making my own decisions. Still, I want whoever is making decisions on my behalf, and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.]

SIGNATURES AND WITNESSES

1. By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

Signature of Declarant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Declarant signed or acknowledged signing this document in my presence and based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

Signature of Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_