*Another resource from* ***PATIENT AND CAREGIVER SUPPORT****

# LIVING WILL DECLARATION

***Dedicated to providing CARE (*Connections, Assistance, Resources and Encouragement*) for patients, caregivers, spouses and families**

**10/10**

If I, _____, should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment will, in the opinion of my attending physician, cause my death within a relatively short time AND I am no longer able to make decisions regarding my medical treatment, ***I direct my attending physician, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.***

List specific life-sustaining treatments you do not want, such as cardiac resuscitation, mechanical respiration (i.e. breathing machine), artificial feeding/fluids by tube, etc. ***Otherwise, your general statement, above, will stand for your wishes.***

I, especially, **do not want**: _____
_____
_____

Add instructions or care that you **do want** – for example: pain medication, a preference to die at home, if possible, etc.

Other instructions/comments: _____
_____
_____

_____ _____
Signature Date

_____
Address City State Zip

**THIS DOCUMENT MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC**

The declarant voluntarily signed this writing in my presence.

Witnessed by_____ _____
Address

Date_____ _____
City/State/Zip

Witnessed by_____ _____
Address

Date_____ _____
City/State/Zip

## -- OR --

**STATE OF_____ )**
**)ss.**
**COUNTY OF _____)**

**The declarant voluntarily signed this document in my presence on this _____ day of _____, 20_____.**

_____
**NOTARY PUBLIC**

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