

# LIVING WILL

## Statutory Short Form

Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully before you initial your selection. You can also write your own statement concerning life sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1,2,3 and 4, but if you initial paragraph 5, the others should not be initialed.

1. \_\_\_ If I have a terminal condition I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.
2. \_\_\_ If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following:  
\_\_\_ (a) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing.  
\_\_\_ (b) Artificially administered food and fluids.  
\_\_\_ (c) To be taken to a hospital if at all avoidable.
3. \_\_\_ Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.
4. \_\_\_ Notwithstanding my other directions, I do want the use of all medical care necessary to treat my condition until my doctors reasonable conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.
5. \_\_\_ I want my life to be prolonged to the greatest extent possible.
6. \_\_\_ This living will is effective only while I am unable to make or communicate my decisions.

### Other or Additional Statements of Desires

I have \_\_\_ I have not \_\_\_ attached additional directives or limitations.

Date: \_\_\_\_\_ Signature or Mark

Of Person Making Living Will \_\_\_\_\_

### Verification

I affirm that: (1) I was present when this living will was dated and signed or marked or (2) that the person making this living will directly indicated to me that the living will expressed that person's wishes and that the person intended to adopt it at that time.

I certify that I have not been designated to make medical decisions for the person who signed this living will, I am not directly involved with the providing health care to that person. I am not related to that person by blood, marriage, or adoption and I am not entitled to any part of that person's estate.

\_\_\_\_\_  
Signature of first Witness

\_\_\_\_\_  
Signature of second Witness

\_\_\_\_\_  
Date Witnessed

\_\_\_\_\_  
Date Witnessed