

# Living Will

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, I,

\_\_\_\_\_, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

- \_\_\_\_\_ I have a terminal condition  
(initial)
- or \_\_\_\_\_ I have an end-stage condition  
(initial)
- or \_\_\_\_\_ I am in a persistent vegetative state  
(initial)

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provision of this declaration:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ (Zip Code)

Phone: \_\_\_\_\_

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

If I have a terminal condition or an end-stage condition or am in a persistent vegetative state and there is no reasonable medical probability of my recovery from such condition (*initial one*):

\_\_\_\_\_ I do NOT want life-prolonging procedures, including artificially provided nutrition and hydration and cardiopulmonary resuscitation (CPR) started. If such procedures have been started, I want them stopped.

\_\_\_\_\_ I want any life-prolonging procedures that my doctors think are best for me.

If I am in any of the conditions described above, I feel very strongly about the following forms of treatment (initial your wishes):

	<u>I do NOT want</u>	<u>I DO want</u>
cardiopulmonary resuscitation (CPR)	_____	_____
mechanical respiration (ventilation)	_____	_____
tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water)	_____	_____
blood or blood products	_____	_____
any form of surgery or invasive diagnostic tests	_____	_____
kidney dialysis	_____	_____
Antibiotics	_____	_____

**Comfort Care** (*initial if this is your wish*)

\_\_\_\_\_ I want to be kept as comfortable and free of pain and suffering as possible, even if such care hastens my death. I expect relief of any pain and suffering that results from my refusal of treatment. For agitation I want sedation, not physical restraint.

**NOTE:** I am aware that I have the right to be involved in all decisions about my medical care, including those not dealing with terminal or end-stage conditions or persistent vegetative state.

**Additional Instructions (optional):**

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**OTHER WISHES:**

**Organ Donation** (*initial one*):

\_\_\_\_\_ I do NOT wish to donate any of my organs or tissues

\_\_\_\_\_ I want to donate all of my organs and tissues

\_\_\_\_\_ I want to donate only these organs and tissues: \_\_\_\_\_

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Other wishes: \_\_\_\_\_

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**Autopsy (initial one):**

\_\_\_\_\_ I do NOT want an autopsy

\_\_\_\_\_ I agree to an autopsy if my doctors request it

**SIGNATURES**

**My signature:**

By my signature below I show that I understand the purpose and effect of this document.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Signature of Two Witnesses:**

One witness shall not be a spouse or blood relative, and the person(s) you appoint as surrogate(s) cannot act as witnesses.

**WITNESS 1:**

Signature: \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**WITNESS 2:**

Signature: \_\_\_\_\_

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

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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**Hemlock Foundation of Florida, Inc.**

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