

# LIVING WILL DECLARATION

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_ (month, year)  
I, \_\_\_\_\_, being of sound mind, willfully  
and voluntarily make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease or illness judged to be a terminal condition by my attending physician who has personally examined me, and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the death process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medicine, sustenance, or the performance of any medical procedure necessary by my attending physician to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

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

Signed: \_\_\_\_\_ DOB: \_\_\_\_\_

City, County & State of Residence: \_\_\_\_\_

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he/she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness: \_\_\_\_\_ Resident at: \_\_\_\_\_

Witness: \_\_\_\_\_ Resident at: \_\_\_\_\_

Copies given to: \_\_\_\_\_

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