

LIVING WILL
of

TO MY FAMILY, PHYSICIAN, LAWYER, CLERGYMAN, ANY MEDICAL FACILITY IN WHOSE CARE I HAPPEN TO BE, AND TO ANY INDIVIDUAL WHO MAY BECOME RESPONSIBLE FOR MY HEALTH, WELFARE, OR AFFAIRS:

I, the undersigned, _____, do fully recognize that death is as much a reality as birth, growth, maturity, and old age -- it is the one certainty of life. If the time comes when I can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If I should have an incurable or irreversible illness, accident, or condition that will cause my death within a relatively short time, it is my desire that my life not be prolonged by administration of life-sustaining procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain. It is my intention that this declaration shall be valid until revoked by me.

This request is made after careful consideration. I hope that you who care for me will feel morally and legally bound to follow its mandate. I recognize that this appears to place a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and of placing it upon myself in accordance with my strong convictions, that this statement is made.

DATED THIS _____ DAY OF _____, 20__.

Witness:

Witness:

Address: _____

Address: _____
