Living Will

Full Name: _____

Date of Birth: ____ / ____ / _____

Address: _____

City: _____ State: _____ ZIP: _____

Declaration

I am of sound mind and voluntarily make this Living Will. If I become unable to make or communicate my healthcare decisions, I want this document to guide my medical care.

Life-Sustaining Treatment

☐ I want life-sustaining treatment if it may help my recovery.

☐ I do not want life-sustaining treatment if I have a terminal condition or am permanently unconscious.

Artificial Nutrition and Hydration

☐ I want tube feeding and fluids.

☐ I do not want tube feeding or artificial hydration.

☐ I want my healthcare provider to decide based on my condition.

Pain Relief and Comfort Care

☐ I want medication and treatments to keep me comfortable, even if they may shorten my life.

Organ and Tissue Donation

☐ I wish to donate my organs and tissues.

☐ I do not wish to donate my organs and tissues.

Additional Instructions

_____

_____

_____

_____

Signature

Signature: _____

Printed Name: _____

Date: ____ / ____ / _____

Witnesses

Witness 1

Name: _____

Signature: _____

Date: ____ / ____ / _____

Witness 2

Name: _____

Signature: _____

Date: ____ / ____ / _____

Notary (If Required by State)

State: _____

County: _____

Notary Public Signature: _____

Commission Expires: _____

Seal: _____