

LIVING WILL / ADVANCE HEALTHCARE DIRECTIVE

I, _____ ("Declarant"), residing at _____, being of sound mind, willfully and voluntarily make this declaration to express my wishes regarding medical treatment.

1. WHEN THIS DIRECTIVE APPLIES

This directive applies when I am: (check all that apply)

- Terminally ill with no reasonable expectation of recovery
- Permanently unconscious
- In an end-stage condition
- Unable to communicate my wishes

2. LIFE-SUSTAINING TREATMENT

I direct that:

Cardiopulmonary Resuscitation (CPR): Yes No Doctor's discretion

Mechanical Ventilation: Yes Time-limited trial No

Artificial Nutrition/Hydration: Yes Time-limited trial No

Dialysis: Yes No Doctor's discretion

Surgery: Yes No Doctor's discretion

Antibiotics: Yes No Doctor's discretion

3. COMFORT CARE

I direct that I receive comfort care/palliative care including pain management even if it may hasten my death. Yes No

4. ORGAN DONATION

I wish to donate organs/tissues I do not wish to donate

Specifically: _____

5. HEALTHCARE AGENT

I appoint _____ as my Healthcare Agent to make medical decisions on my behalf when I cannot.

Alternate Agent: _____

6. HIPAA AUTHORIZATION

My Healthcare Agent is authorized to access all medical records and information necessary to make informed decisions.

7. PREGNANCY

If I am pregnant when this directive would otherwise apply:

8. RELIGIOUS/PERSONAL CONSIDERATIONS

9. EFFECT

This directive remains in effect unless I revoke it in writing or orally to my doctor.

DECLARANT SIGNATURE:

Signature: _____ Date: _____

WITNESS ATTESTATION

We attest that Declarant signed this directive in our presence and appeared to be of sound mind and free from coercion. We are not related to Declarant by blood, marriage, or adoption, nor are we entitled to any portion of Declarant's estate.

WITNESS 1: Signature: _____ Date: _____

Printed Name: _____

WITNESS 2: Signature: _____ Date: _____

Printed Name: _____

NOTARIZATION (if required by state):

State of _____, County of _____

Subscribed before me on ____ day of _____, 20__.

Notary Signature: _____ Commission expires: _____

DISCLAIMER: This template is for informational purposes only and does not constitute legal advice. Laws vary by state. Consult a licensed attorney before executing this agreement.