ADVANCE DIRECTIVE FOR MEDICAL/SURGICAL TREATMENT
(Living Will)

This form may be used to make your wishes known about what medical treatment or other care you would or would not want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

DEFINITIONS

Terminal Condition: An incurable or irreversible condition for which the administration of life-sustaining procedures will serve only to postpone the moment of death.

Life-Sustaining Procedure: Any medical procedure or intervention that, if administered to a qualified patient, would serve only to prolong the dying process. "Life-sustaining procedure" shall not include any medical procedure or intervention for nutrition or hydration of the qualified patient or considered necessary by the attending physician or advanced practice nurse to provide comfort or alleviate pain.

Persistent Vegetative State: "Persistent Vegetative State" is not specifically defined by this description but rather is defined by reference to the criteria and definitions employed by the prevailing medical community standards of practice. It generally includes a medical state in which an attending physician and another doctor, qualified to make such diagnosis, agree that, within a reasonable degree of medical probability, the patient can no longer think, feel anything, knowingly move, or be aware of being alive. The physicians must agree this condition will last indefinitely without hope for improvement and they must have monitored the patient long enough to make that decision.

DECLARATION

I, _____, being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and I hereby declare that:

I. TERMINAL CONDITION

If at any time my attending physician and one other physician who has examined me certify in writing that:

a) I have a terminal condition, and

b) I am unable to effectively receive or evaluate information, or communicate decisions concerning my person, then:

1. Life-Sustaining Procedures (INITIAL ONLY ONE)

_____ (Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nutrition or hydration or considered necessary by the attending physician to provide comfort or alleviate pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued for a period of not less than _____ days, and if there be no change in my condition that would indicate to my physicians that my prognosis has improved, then I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nutrition or hydration or considered necessary by the attending physician to provide comfort or alleviate pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued indefinitely, regardless of my prognosis, if medically feasible and advisable in the determination of my physicians.

2. Artificial Nutrition or Hydration

In the event that I am being provided artificial nutrition or hydration, I direct that one of the following actions be taken **(INITIAL ONLY ONE)**:

_____ (Initials) Artificial nutrition or hydration shall not be continued.

_____ (Initials) Artificial nutrition or hydration shall be continued for _____ days.

_____ (Initials) Artificial nutrition or hydration shall be continued, if medically feasible and advisable in the determination of my physicians.

II. PERSISTENT VEGETATIVE STATE

If at any time my attending physician and one other physician who has examined me certify in writing that I am in a persistent vegetative state, then:

1. Life-Sustaining Procedures (INITIAL ONLY ONE)

_____ (Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nutrition or hydration or considered necessary by the attending physician to provide comfort or alleviate pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued for a period of _____ days, and if there be no change in my condition that would indicate to my physicians that my prognosis has improved, then I direct that life-sustaining procedures shall be withdrawn and/or

withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nutrition or hydration or considered necessary by the attending physician to provide comfort or alleviate pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued indefinitely, regardless of my prognosis, if medically feasible and advisable in the determination of my physicians.

2. Artificial Nutrition or Hydration:

In the event that I am being provided artificial nutrition or hydration, I direct that one of the following actions be taken **(INITIAL ONLY ONE)**:

_____ (Initials) Artificial nutrition or hydration shall not be continued.

_____ (Initials) Artificial nutrition or hydration shall be continued for _____ days.

_____ (Initials) Artificial nutrition or hydration shall be continued, if medically feasible and advisable in the determination of my physicians.

III. OTHER DIRECTIONS

_____

_____

_____

_____

If you do not have other directions, place your initials here:

_____ No, I do not have any other directions.

IV. RESOLUTION WITH MEDICAL POWER OF ATTORNEY

I have executed a medical power of attorney, naming an agent to make medical decisions for me in the event of my inability to make medical decisions for myself. In the event that the decisions of my agent under my medical power of attorney shall conflict with this instrument **(INITIAL ONLY ONE)**:

_____ My agent under my medical power of attorney shall have the authority to override my preferences as stated in this instrument, whether this instrument was executed before or after appointment of my agent under my medical power of attorney.

_____ My preferences as stated in this instrument shall prevail over the wishes of my agent under my medical power of attorney, whether this instrument was executed before or after appointment of my agent under my medical power of attorney.

_____ I have not executed a medical power of attorney.

V. COMMUNICATION WITH INTERESTED PARTIES

I give the following persons permission to communicate with my health care providers about my condition if I am in a terminal condition or persistent vegetative state. This does not give these persons legal power to speak for me or make decisions about my treatment, but it does give my consent for my health care providers to talk with them about my condition.

I hereby waive any requirements of Public Law 104-191 and supporting CFRs, otherwise known as the Health Insurance Portability and Accountability Act of 1996, as amended, or HIPAA, concerning release of medical information by my medical care providers to these individuals. This direction does NOT authorize these individuals to make medical decisions on my behalf, unless such person(s) also is my agent under medical power of attorney. (This section

shall be considered valid regardless of whether or not the categories of "relationship" and "telephone number" are completed.):

Name	Relationship	Telephone number
_____	_____	_____
_____	_____	_____

VI. ORGAN/TISSUE DONATION

In the event of my death, if my organs and/or tissues may be used **(INITIAL ONLY ONE)**:

_____ I wish to be an organ and/or tissue donor, if medically feasible.

_____ I do not wish to be an organ and/or tissue donor.

I execute this declaration, as my free and voluntary act, this _____ day of _____ _____, 20___.

_____

Declarant

DECLARATION OF WITNESSES

The foregoing instrument was signed and declared by _____ to be the declarant's declaration, in the presence of us, who, in the presence of the declarant, in the presence of each other, and at the declarant's request, have signed our names below as witnesses, and we declare that, at the time of the execution of this instrument, the declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence.

Each witness states that: I did not sign the declarant's signature, and I am not a physician; an employee of the attending physician or health care facility in which the declarant is a patient; a person who has a claim against any portion of the estate of the declarant at the declarant's death at the time this declaration was signed; a person who knows or believes I am entitled to any portion of the estate of the declarant upon the declarant's death either as a beneficiary of a will in existence at the time this declaration was signed, or an heir at law. I am eighteen (18) years of age or older, and under no form of coercion, undue influence, or otherwise disqualifying disability.

_____	_____
Signature of Witness	Signature of Witness
_____	_____
_____	_____
Address	Address