

IF AT ANY TIME I SHOULD HAVE AN INCURABLE INJURY, DISEASE, OR ILLNESS CERTIFIED TO BE A TERMINAL CONDITION BY TWO (2) PHYSICIANS WHO HAVE PERSONALLY EXAMINED ME, ONE (1) OF WHOM SHALL BE MY ATTENDING PHYSICIAN, AND THE PHYSICIANS HAVE DETERMINED THAT MY DEATH IS IMMINENT AND WILL OCCUR WHETHER OR NOT LIFE-SUSTAINING PROCEDURES ARE UTILIZED AND WHERE THE APPLICATION OF SUCH PROCEDURES WOULD SERVE ONLY TO ARTIFICIALLY PROLONG THE DYING PROCESS, I DIRECT THAT SUCH PROCEDURES BE WITHHELD OR WITHDRAWN, AND THAT I BE PERMITTED TO DIE NATURALLY WITH ONLY THE ADMINISTRATION OF MEDICATION, THE ADMINISTRATION OF FOOD AND WATER, AND THE PERFORMANCE OF ANY MEDICAL PROCEDURE THAT IS NECESSARY TO PROVIDE COMFORT CARE OR ALLEVIATE PAIN. IN THE ABSENCE OF MY ABILITY TO GIVE DIRECTIONS REGARDING THE USE OF SUCH LIFE-SUSTAINING PROCEDURES, IT IS MY INTENTION THAT THIS DECLARATION SHALL BE HONORED BY MY FAMILY AND PHYSICIAN(S) AS THE FINAL EXPRESSION OF MY RIGHT TO CONTROL MY MEDICAL CARE AND TREATMENT.

DECLARATION MADE THIS _____ DAY OF _____ (MONTH, YEAR). I, _____, BEING OF SOUND MIND, WILLFULLY AND VOLUNTARILY DIRECT THAT MY DYING SHALL NOT BE ARTIFICIALLY PROLONGED UNDER THE CIRCUMSTANCES SET FORTH BELOW AND-DO-HEREBY-DECLARE IN THIS DECLARATION:

IF--AT--ANY--TIME--I--AM--TERMINALLY--ILL,--UNABLE--TO--PARTICIPATE--MEANINGFULLY--IN--DECISIONS--REGARDING--MY--MEDICAL--CARE--AND--TREATMENT--AND--EXPECTED--TO--REMAIN--SO,--AND--HAVE--BEEN--SO--CERTIFIED--BY--2--PHYSICIANS,--1--OF--WHOM--IS--MY--ATTENDING--PHYSICIAN,--AND--BOTH--OF--WHOM--HAVE--ALSO--CERTIFIED--THAT--WITH--OR--WITHOUT--LIFE-SUSTAINING--PROCEDURES,--I--CANNOT--RECOVER--AND--THAT,--WITHOUT--LIFE-SUSTAINING--PROCEDURES,--MY--DEATH--IS--IMMINENT,--I--DIRECT--THAT--THESE--PROCEDURES--BE--WITHHELD--OR--WITHDRAWN--AND--THAT--I--BE--PERMITTED--TO--DIE--NATURALLY--WITH--ONLY--THE--ADMINISTRATION--OF--FOOD--AND--WATER--AND--SUCH--MEDICATION--AND--MEDICAL--PROCEDURES--AS--ARE--NECESSARY--TO--PROVIDE--ME--WITH--COMFORT--CARE--AND--TO--ALLEVIATE--PAIN.

THIS--DECLARATION--SHALL--BE--REGARDED--BY--MY--FAMILY--AND--PHYSICIAN(S)--AS--THE--FINAL--EXPRESSION--OF--MY--INTENTION--AND--DESIRE--TO--REFUSE--LIFE-SUSTAINING--PROCEDURES--AND--ACCEPT--THE--CONSEQUENCES--OF--THIS--REFUSAL.

I AM AN ADULT OF SOUND MIND AND OTHERWISE LEGALLY COMPETENT TO MAKE THIS DECLARATION, AND I UNDERSTAND ITS FULL IMPORT.

SIGNED _____

ADDRESS _____

UNDER PENALTY OF PERJURY, WE STATE THAT THIS DECLARATION WAS SIGNED BY _____ IN THE PRESENCE OF THE