

# LIVING WILL

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_,

**1.** I, \_\_\_\_\_, being  
(Print clearly)

of sound mind, hereby willfully and voluntarily make known my desire that my life not be artificially prolonged by life-sustaining procedures except as I may otherwise provide in this directive. I understand that the term “life-sustaining procedure”, as defined by law, I) means any medical procedure or intervention which, when applied to a person who has a terminal condition would, in the judgment of the attending physician serve only to prolong the dying process, ii) does not mean medication, sustenance or medical procedures for providing comfort, care, or for alleviating pain, unless I so specify below.

**2.** I declare that if at any time I should have an injury, disease or illness, which is certified in writing to be a terminal condition by two physicians who have personally examined me, and in the opinion of those physicians the application of life-sustaining procedures would serve only to unnaturally prolong the moment of my death and to unnaturally postpone or prolong the dying process, I direct that these procedures be withheld or withdrawn and my death be permitted to occur naturally.

**3.** I expressly intend this directive to be a final expression of my legal right to refuse medical or surgical treatment and to accept the consequences from this refusal, which shall remain in effect notwithstanding my future inability to give current medical directions to treating physicians and other providers of medical services.

-Continued-

**4.** I understand that the term “life-sustaining procedure” does not include the administration of medication or sustenance, or the performance of any medical procedure deemed necessary to provide comfort care, or to alleviate pain, except to the extent I specify below that any of these procedures be considered life-sustaining:\_\_\_\_\_

\_\_\_\_\_

**5.** I reserve the right to give current medical directions to physicians and other providers of medical services so long as I am able, even though these directions may conflict with the above written directive that life-sustaining procedures be withheld or withdrawn.

**6.** I understand the full import of this directive and declare that I am emotionally and mentally competent to make this directive.

\_\_\_\_\_  
Declarant Signature

\_\_\_\_\_  
City/County/State of residence

We, the witnesses, certify that each of us is 18 years of age or older and each personally witnessed the declarant sign or direct the signing of this directive; that we are acquainted with the declarant and believe him/her to be of sound mind; that the declarant's desires are as expressed above; that neither of us is a person who signed the above directive on behalf of the declarant; that we are not related to the declarant by blood or marriage nor are we entitled to any portion of declarant's estate according to the laws of intestate succession of this state or under any Will or Codicil of declarant; that we are not directly financially responsible for declarant's medical care; and that we are not agents of any health care facility in which the declarant may be a patient at the time of signing this directive.

**Witness #1**

**Witness #2**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code



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For assistance, please call Steve Rasmussen at (801) 647-6907