LIVING WILL FORM

If I should be in an incurable or irreversible condition, with no reasonable expectation of recovery, or if there is little likelihood that I will return to a conscious state of self-awareness, I direct all of my health care providers to withhold or withdraw treatments which merely prolong my dying. If my physicians reasonably believe that certain procedures or treatments may lead to recovery, those procedures or treatments may be tried for a period of time, but are to be withdrawn if they do not significantly improve my condition or provide comfort.

Comments: _____

_____

I specifically direct that treatments which will keep me comfortable and relieve pain are to be provided.

Comments: _____

_____

In addition to comfort measures, I specifically request: _____

_____

I especially do not want the following: _____

_____

My other instructions and comments are: _____

_____

ORGAN DONATION

After my death, I wish to donate my organs for use in transplantation.

Limitations: _____

ATTESTATION

These instructions express my legal right to bodily self-determination. They reflect my firm and settled commitment, made with calm and deliberate resolve. I intend this document to be treated as clear and convincing evidence of my wishes.

_____ _____

Signature Date

WITNESSES' DECLARATION

We declare that _____ signed this document (or directed another person to sign it) in our presence, willingly and free from duress.

_____ _____

Witness Signature **Witness Signature**

Print name _____ **Print name** _____

Address _____ **Address** _____

RE-AFFIRMATION

I have reviewed and reaffirmed this Proxy and Advance Directive, and I declare that it still expresses my wishes

Initials	**Date**	**Initials**	**Date**
_____	_____	_____	_____
_____	_____	_____	_____

95380A (Rev. 07/03)

[**OPTIONAL.** Cross out and initial any sections which do not express your wishes, or make changes as you see fit.]

[You may wish to give special consideration to cardiopulmonary resuscitation (CPR); mechanical breathing devices; artificial feeding or fluids administered through tubes; kidney dialysis; antibiotics; or surgery.]

[**OPTIONAL.** Cross out and initial if not desired.]

[If you are unable to sign, you may direct another person to sign for you in your presence.]

[This document must be signed in front of two witnesses who are at least 18 years old. **The persons named as Agent or Alternate may not act as witnesses.**]

[**OPTIONAL.** You may wish to periodically review and initial this document.]