LIVING WILL AND APPOINTMENT OF HEALTHCARE SURROGATE

I, ______________________________, want to choose how I will be treated by my physicians and other healthcare providers. If there comes a time when I am unable to communicate or make my own healthcare decisions because of illness or injury, I direct my physicians, my healthcare surrogate, and my family to honor this living will.

Part 1—Appoint a Healthcare Surrogate

In the event I am unable to communicate or I am incapable of making decisions about receiving, withholding, or withdrawing medical procedures or other treatments, I designate my healthcare surrogate to make choices for me according to his/her understanding of my wishes and values.

My Appointed Healthcare Surrogate is:	
Name:	
Address:	
Phone:	Alt. Phone:

If my surrogate is unable or unwilling, then my next choice (Alternate Surrogate) is:	
Name:	
Address:	
Phone:	Alt. Phone:

Part 2—Indicate Your Wishes

I understand that this living will only becomes effective when I am no longer able to communicate or when I am not capable of making my healthcare decisions. When two physicians have determined that I have one of the following:

- A terminal or end-stage condition, and there is little or no chance of recovery
- A condition of permanent and irreversible unconsciousness, such as coma or vegetative state
- An irreversible and severe mental or physical illness that prevents me from communicating with others, recognizing my family and friends, or caring for myself in any way

Then I want my doctors and others to provide comfort (palliative) care including relief of all physical pain, suffocation and mental anguish. If I develop one of the above conditions, my treatment choices are:

My Specific Choices if I have one of the above conditions	**Yes, I Want**	**No, I Do Not Want**
Cardio-pulmonary resuscitation (CPR) if my heart or breathing stops	YES	NO
A breathing machine if I am unable to breathe on my own	YES	NO
Nutrition and fluids through tubes in my veins, nose or stomach	YES	NO
Kidney dialysis, a pacemaker or defibrillator, or other such machines	YES	NO
Surgery or admission to a hospital Intensive Care Unit	YES	NO
Medications that can prolong my dying, such as antibiotics	YES	NO
I want Hospice involved in my care at the earliest opportunity	YES	NO

If a medical decision has to be made for me and my decision is not indicated above, I want my healthcare surrogate to make and communicate these decisions for me.

Other Information (optional)

Quality of life is important to me. These are the things that give my life quality:

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Part 3—Make it Legal

I fully understand the meaning of this declaration, I am emotionally and mentally competent to make this declaration, and have given this declaration careful consideration.

_____________________________________ ______________ __________________________
Signature Date Print Name

*Witness 1:___________________________________ ______________________________________
Signature of Witness 1 Print Name

Address:____

*Witness 2:___________________________________ ______________________________________
Signature of Witness 2 Print Name

Address:____

**Your healthcare surrogate(s) cannot serve as a witness to this living will. At least one witness must be someone other than your spouse or a blood relative.*