

**LIVING WILL  
OF**

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(Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully before you initial your selection. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3 and 4 but if you initial paragraph 5 the others should not be initialed.)

- \_\_\_\_\_ 1. If I have a terminal condition, I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.
- \_\_\_\_\_ 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following:
- \_\_\_\_\_ (a) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing.
- \_\_\_\_\_ (b) Artificially administered food and fluids.
- \_\_\_\_\_ (c) To be taken to a hospital, if at all avoidable.
- \_\_\_\_\_ 3. Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.
- \_\_\_\_\_ 4. Notwithstanding my other directions, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

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\_\_\_\_\_ 5. I want my life to be prolonged to the greatest extent possible.

I have \_\_\_\_\_ I have not \_\_\_\_\_ attached additional special provisions or limitations to this document to be honored in the absence of my being able to give health care directions.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Principal

Witness:

Witness (if more than one):

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address