

Wyoming Living Will

NOTICE

This document has significant medical, legal and possible ethical implications and effects. Before you sign this document, you should become completely familiar with these implications and effects. The operation, effects and implications of this document may be discussed with a physician, a lawyer and a clergyman of your choice.

The following declaration must dated and signed by the person making the declaration, or by another person in the declarant's presence and by the declarant's expressed direction, and in the presence of two (2) or more adult witnesses. The witnesses shall not be:

- (i) The person who signed the declaration on behalf of and at the direction of the person making the declaration;
- (ii) Related to the declarant by blood or marriage;
- (iii) Entitled to any portion of the estate of the declarant according to laws of intestate succession of this state or under any will of the declarant or codicil thereto; or
- (iv) Directly financially responsible for declarant's medical care.

DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____ (name), being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease or other 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 will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

If, in spite of this declaration, I am comatose or otherwise unable to make treatment decisions for myself, I HEREBY designate _____ to make treatment decisions for me.

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this declaration shall be honored by my family and

physician(s) and agent as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from this refusal. I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

Date _____

City, County and State of Residence

....

The declarant has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness _____

Printed Name _____

Date _____

Witness _____

Printed Name _____

Date _____