

DECLARATION OF LIVING WILL
(Two pages with Witness or Notary)

Declaration made on _____ (date).

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below and declare that:

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians who have determined that my death will occur unless life-sustaining procedures are used and if the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that life-sustaining procedures be withheld or withdrawn and that I be permitted to die naturally with only the performance of medical procedures deemed necessary to provide me with comfort care.

Other instructions:

If and when I am no longer mentally competent and there is little or no likelihood that I will regain mental competence as determined by my physicians, I not only request but demand that the following additional instructions for my care be followed:

1. If I am no longer able to eat in a normal manner, I do not wish to have my life prolonged by intravenous feedings and fluids, nor nasogastric, nor other gastric feedings. It is my wish to die, if nutrition cannot be provided in the normal manner.

2. In the event of infections, including pneumonia or other serious infections, I do not want parenteral antibiotics or oral antibiotics which in any way could be interpreted as life-saving. If treatment will make nursing care easier, or if needed to prevent the spread of contagious infection, then appropriate treatment can be given. Urinary tract infections can be treated only by the oral route; I refuse any parenteral antibiotics. Topical treatments can be provided to improve nursing care.

I wish to reemphasize that when I am no longer mentally competent, it is my wish to die in a normal course of events without benefit of medical intervention. If I am at home and can be taken care of there, I do not wish to be taken to a hospital for specific treatment, except in the case when nursing care is required that cannot be provided at home. If I am in a nursing home and become ill, I do not wish to be transferred to a hospital, the only exception being when it is impossible to provide that nursing care in the nursing home. Specifically, I refuse permission to be transferred to the hospital, if the purpose is to prolong my life.

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this declaration be honored by my family and attending physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full impact of this declaration, and I am emotionally and mentally competent to make this declaration.

(Declarant Signature)

City, County and State of Residence:

SIGNATURE OF WITNESS OR NOTARY PUBLIC
(Living Will must be signed in front of either a Witness or a Notary Public)

WITNESS:

The declarant is personally known to me and I believe him or her to be an adult and of sound mind. I am not:

1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the decedent's estate either by will or codicil or according to the laws of intestate succession;
3. Directly financially responsible for the declarant's medical care;
4. The declarant's doctor or an employee of that doctor;
5. An employee or patient in the hospital where the declarant is a patient.

(Witness Signature)

(Witness Printed Name)

(Street Address)

(City) Arizona (Zip)

NOTARY:

STATE OF ARIZONA)
) ss
COUNTY OF _____)

The foregoing Living Will was acknowledged before me, a Notary Public, on _____, by _____, the person making this Living Will who has dated and signed in my presence, and appears to me to be of sound mind and free from duress. I further declare that: I am not related to the person signing above, by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf; I am not directly involved in providing health care to the person signing; and I am not entitled to any part of his/her estate under a will now existing or by operation of law.

Notary Public

Commission Seal/Expiration Date: