LIVING WILL DECLARATION

Declaration made this_____day of_____ , 20_____. I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration.

(Indicate your choice by initialing or making your mark before signing the Declaration.):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under I.C. § 16-36-1-7 or my attorney in fact with health care powers under I.C. § 30-5-5.

_____ I wish to donate organs upon my death as follows:

_____

_____

_____ I do not wish to donate organs upon my death.

_____ I intentionally make no decision concerning the issue of donating organs upon my death, leaving the decision to my health care representative appointed under I.C. § 16-36-1-7 or my attorney in fact with health care powers under I.C. § 30-5-5.

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

I understand the full import of this Declaration.

_____
Signature

_____
Name Printed

City of_____

County of _____
State of Indiana

The declarant has been personally known to me, and I believe he/she 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 a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Date: _____ _____
Witness

Date: _____ _____
Witness