(ATTENDING PHYSICIAN) DECIDES THAT I HAVE LOST THIS ABILITY **TEMPORARILY**, OR MY ATTENDING PHYSICIAN AND A CONSULTING DOCTOR AGREE THAT I HAVE LOST THIS ABILITY **PERMANENTLY**.

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IF THE ONLY THING YOU WANT TO DO IS SELECT A HEALTH CARE AGENT, SKIP PART II. GO TO PART III TO SIGN AND HAVE THE ADVANCE DIRECTIVE WITNESSED. IF YOU ALSO WANT TO WRITE YOUR TREATMENT PREFERENCES, USE PART II. ALSO CONSIDER BECOMING AN ORGAN DONOR, USING THE SEPARATE FORM FOR THAT.

PART II: TREATMENT PREFERENCES ("LIVING WILL")

A. STATEMENT OF GOALS AND VALUES
(OPTIONAL; FORM VALID IF LEFT BLANK)

I WANT TO SAY SOMETHING ABOUT MY GOALS AND VALUES, AND ESPECIALLY WHAT'S MOST IMPORTANT TO ME DURING THE LAST PART OF MY LIFE:

_____
_____
_____
_____
_____
_____

B. PREFERENCE IN CASE OF TERMINAL CONDITION
(IF YOU WANT TO STATE YOUR PREFERENCE, INITIAL ONE ONLY. IF YOU DO NOT WANT TO STATE A PREFERENCE HERE, CROSS THROUGH THE WHOLE SECTION.)

IF MY DOCTORS CERTIFY THAT MY DEATH FROM A TERMINAL CONDITION IS IMMINENT, EVEN IF LIFE-SUSTAINING PROCEDURES ARE USED:

1. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO NOT WANT ANY MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE. I DO NOT WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL MEANS.

_____

((OR))

2. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO NOT WANT MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE. IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT BY MOUTH, HOWEVER, I WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL MEANS.

_____

((OR))