

FORM I

LIVING WILL

(OPTIONAL FORM)

IF I AM NOT ABLE TO MAKE AN INFORMED DECISION REGARDING MY HEALTH CARE, I DIRECT MY HEALTH CARE PROVIDERS TO FOLLOW MY INSTRUCTIONS AS SET FORTH BELOW. (INITIAL THOSE STATEMENTS YOU WISH TO BE INCLUDED IN THE DOCUMENT AND CROSS THROUGH THOSE STATEMENTS WHICH DO NOT APPLY.)

A. IF MY DEATH FROM A TERMINAL CONDITION IS IMMINENT AND EVEN IF LIFE-SUSTAINING PROCEDURES ARE USED THERE IS NO REASONABLE EXPECTATION OF MY RECOVERY -

_____ I DIRECT THAT MY LIFE NOT BE EXTENDED BY LIFE-SUSTAINING PROCEDURES, INCLUDING THE ADMINISTRATION OF NUTRITION AND HYDRATION ARTIFICIALLY.

_____ I DIRECT THAT MY LIFE NOT BE EXTENDED BY LIFE-SUSTAINING PROCEDURES, EXCEPT THAT, IF I AM UNABLE TO TAKE FOOD BY MOUTH, I WISH TO RECEIVE NUTRITION AND HYDRATION ARTIFICIALLY.

_____ I DIRECT THAT, EVEN IN A TERMINAL CONDITION, I BE GIVEN ALL AVAILABLE MEDICAL TREATMENT IN ACCORDANCE WITH ACCEPTED HEALTH CARE STANDARDS.

B. IF I AM IN A PERSISTENT VEGETATIVE STATE, THAT IS IF I AM NOT CONSCIOUS AND AM NOT AWARE OF MY ENVIRONMENT NOR ABLE TO INTERACT WITH OTHERS, AND THERE IS NO REASONABLE EXPECTATION OF MY RECOVERY WITHIN A MEDICALLY APPROPRIATE PERIOD -

_____ I DIRECT THAT MY LIFE NOT BE EXTENDED BY LIFE-SUSTAINING PROCEDURES, INCLUDING THE ADMINISTRATION OF NUTRITION AND HYDRATION ARTIFICIALLY.

_____ I DIRECT THAT MY LIFE NOT BE EXTENDED BY LIFE-SUSTAINING PROCEDURES, EXCEPT THAT IF I AM UNABLE TO TAKE IN FOOD BY MOUTH, I WISH TO RECEIVE NUTRITION AND HYDRATION ARTIFICIALLY.

_____ I DIRECT THAT I BE GIVEN ALL AVAILABLE MEDICAL TREATMENT IN ACCORDANCE WITH ACCEPTED HEALTH CARE STANDARDS.

C. IF I AM PREGNANT MY AGENT SHALL FOLLOW THESE SPECIFIC INSTRUCTIONS:

BY SIGNING BELOW, I INDICATE THAT I AM EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS LIVING WILL AND THAT I UNDERSTAND ITS PURPOSE AND EFFECT.