LIVING WILL (ADVANCE DIRECTIVE)

1. 1. Declaration and Identification

I, [FULL LEGAL NAME], date of birth [DATE OF BIRTH], residing at [STREET ADDRESS], [CITY], [COUNTY] County, State of [STATE], being of sound mind and able to make and communicate health care decisions, make this Living Will and Advance Health Care Directive. I make it willingly, free of duress or undue influence, and I intend it to be honored by my family, my physicians, and any health care institution treating me as the expression of my legal right to accept or refuse medical treatment. My primary physician is [PHYSICIAN NAME], of [PHYSICIAN PRACTICE AND PHONE]. This document revokes any prior living will or health care declaration I have signed.

2. 2. When This Declaration Takes Effect

This Declaration takes effect only if I am unable to make or communicate my own health care decisions, as determined by my attending physician, and one of the following conditions applies: (a) I have an incurable and irreversible condition that will result in my death within a relatively short time; (b) I am unconscious and, to a reasonable degree of medical certainty, will not regain consciousness; or (c) [ADDITIONAL CONDITION, e.g., I have advanced, progressive dementia and can no longer recognize family or communicate meaningfully]. I direct that the determination be made by my attending physician and confirmed by [NUMBER, e.g., one] additional physician who has personally examined me, and that the determination be documented in my medical record. While I am able to communicate my own decisions, my current instructions control over anything written here.

3. 3. Election Regarding Life-Sustaining Treatment

If the conditions in Section 2 are met, I direct my health care providers as follows. Initial or mark only one election. [ ] OPTION A — COMFORT CARE ONLY: I direct that life-sustaining treatment be withheld or withdrawn and that I be permitted to die naturally, with only the care necessary to keep me comfortable and free of pain. [ ] OPTION B — TIME-LIMITED TRIAL: I direct that life-sustaining treatment be provided for a trial period of [NUMBER OF DAYS] days, and that if my condition has not improved to a degree my physicians consider meaningful by the end of that period, the treatment be withdrawn. [ ] OPTION C — ALL AVAILABLE TREATMENT: I direct that my life be prolonged to the greatest extent possible using all life-sustaining treatment consistent with accepted medical standards, regardless of my prognosis or the expected quality of my recovery. [ ] OPTION D — SPECIFIC DIRECTION: [WRITE YOUR OWN INSTRUCTION HERE]. My initials confirming the option selected: ____.

4. 4. Specific Treatments

Within the election made in Section 3, I give the following specific directions. Mark each line. Cardiopulmonary resuscitation: [ ] I want it / [ ] I do not want it / [ ] Only if my physician believes recovery is likely. Mechanical ventilation or a breathing machine: [ ] I want it / [ ] I do not want it / [ ] Only for a trial period of [NUMBER OF DAYS] days. Dialysis: [ ] I want it / [ ] I do not want it / [ ] Only for a trial period. Antibiotics and other infection treatment: [ ] I want them / [ ] I want them only to keep me comfortable / [ ] I do not want them. Blood transfusions: [ ] I want them / [ ] I do not want them. Surgery, other than surgery to relieve pain or discomfort: [ ] I want it / [ ] I do not want it. Additional instructions or treatments I specifically refuse: [ADDITIONAL INSTRUCTIONS].

5. 5. Artificial Nutrition and Hydration

Artificial nutrition and hydration means food and fluids delivered through a feeding tube, an intravenous line, or a

similar medical device, and it is treated separately from other life-sustaining treatment in many states. My direction is: [ ] I do not want artificial nutrition or hydration, and I understand that this may hasten my death. [ ] I want artificial nutrition and hydration to be provided even if all other life-sustaining treatment is withheld or withdrawn. [ ] I want a trial of artificial nutrition and hydration for [NUMBER OF DAYS] days, after which it should be withdrawn if my condition has not improved. [ ] I leave this decision to my health care agent named in my medical power of attorney. My initials confirming this election: ____. In all cases, I want my mouth and lips kept moist and I want to be offered food and water by mouth if I am able to take them and doing so does not cause me harm.

6. 6. Pain Relief and Comfort Care

Regardless of any other instruction in this Declaration, I want to receive medication, oxygen, positioning, hygiene, and any other treatment necessary to relieve pain, agitation, breathlessness, nausea, and other distressing symptoms, and to keep me as comfortable and as free of suffering as reasonably possible. I direct that pain medication be given in the dose necessary to relieve my symptoms even if it may have the secondary effect of shortening my life or making me less alert. I do not intend this Declaration to authorize any act or omission that is unlawful in my state, and nothing in it should be read as a request for assisted death. Additional comfort care wishes: [COMFORT CARE PREFERENCES, e.g., music, religious or spiritual support, presence of family, preference to be cared for at home or in hospice].

7. 7. Preferred Place of Care and Hospice

If my condition allows a choice, I prefer to receive care in the following setting, listed in order of preference: [FIRST CHOICE, e.g., at home with hospice support], then [SECOND CHOICE], then [THIRD CHOICE]. I [ ] do / [ ] do not want to be enrolled in hospice care when I become eligible, and I authorize my agent and my physicians to arrange that enrollment. I ask that transfers between facilities be avoided in my final days unless a transfer is needed for my comfort. I would like the following people to be permitted to visit me: [VISITORS], and I direct that [ANY PERSON TO BE EXCLUDED, OR STATE "no restrictions"] be excluded from visiting.

8. 8. Pregnancy

If I am pregnant at the time this Declaration would otherwise take effect, my direction is: [ ] This Declaration should be given full effect regardless of my pregnancy. [ ] Life-sustaining treatment should be provided if, in the medical judgment of my physicians, the fetus could develop to the point of live birth with continued treatment and continued treatment is not harmful to me or unduly painful. [ ] [OTHER INSTRUCTION]. I understand that several states restrict or suspend the operation of an advance directive during pregnancy by statute, and that my direction here may be limited by the law of the state where I am treated.

9. 9. Anatomical Gifts and Autopsy

Organ and tissue donation: [ ] I wish to donate any needed organs, tissues, or eyes. [ ] I wish to donate only the following: [SPECIFIC ORGANS OR TISSUES]. [ ] I do not wish to donate any organs or tissues. I understand that a decision to donate may require limited, temporary medical treatment after death is declared solely to preserve organs, and I [ ] authorize / [ ] do not authorize that treatment. Donation of my body for medical study or education: [ ] I authorize donation to [INSTITUTION NAME] / [ ] I do not authorize it. Autopsy: [ ] I consent to an autopsy if my physician or family requests one / [ ] I do not consent to an autopsy except where required by law. My decision on donation here is intended to supplement, not replace, any donor registration on my drivers license or in a state donor registry.

10. 10. Relationship to My Health Care Agent and Other Documents

I have [ ] signed / [ ] not signed a separate medical power of attorney naming [AGENT FULL NAME], of [AGENT ADDRESS], telephone [AGENT PHONE], as my health care agent, with [ALTERNATE AGENT FULL NAME] as alternate. My agent has authority to make health care decisions for me that this Declaration does not address, to interpret this Declaration in situations it did not anticipate, and to consent to or refuse treatment consistent with my wishes stated here. If my agent believes my written instruction does not fit my actual medical circumstances, my direction is that [ ] my written instruction in this Declaration controls / [ ] my agent judgment controls. I intend for both documents to be read together, and I ask that copies of both be placed in my medical record.

11. 11. Copies, Revocation, and Effect

A photocopy, scan, or electronic image of this signed Declaration has the same effect as the original. I direct that copies be given to my physician, my health care agent, my alternate agent, and to [OTHER RECIPIENTS, e.g., family members, hospital, care facility], and that a copy be placed in my medical record on any admission. I may revoke this Declaration at any time and in any manner that communicates my intent to revoke, including by destroying it, by signing a written revocation, or by telling my physician or another health care provider, regardless of my mental or physical condition at the time. Revocation is effective when it is communicated to my attending physician or other health care provider, who should record it in my medical record. I release my health care providers, my agent, and any institution acting in good faith under this Declaration from liability to the extent permitted by the law of the State of [STATE].

12. 12. Signature, Witnesses, and Notarization

I sign this Declaration on [DATE] at [CITY], [STATE]. DECLARANT: [FULL LEGAL NAME]. Signature: _____. WITNESSES: I declare that the Declarant signed this Declaration in my presence, that the Declarant appears to be of sound mind and free of duress or undue influence, that I am at least eighteen years of age, and that I am not related to the Declarant by blood, marriage, or adoption, am not entitled to any part of the estate of the Declarant, am not financially responsible for the health care of the Declarant, and am not the attending physician or an employee of the health care facility treating the Declarant. WITNESS 1: Signature: _____. Printed Name: [WITNESS 1 NAME]. Address: [WITNESS 1 ADDRESS]. Date: [DATE]. WITNESS 2: Signature: _____. Printed Name: [WITNESS 2 NAME]. Address: [WITNESS 2 ADDRESS]. Date: [DATE]. NOTARY (if required or preferred in your state): State of [STATE], County of [COUNTY]. Subscribed and sworn before me on [DATE] by [FULL LEGAL NAME]. Notary Public: _____. My commission expires: [EXPIRATION DATE]. [Seal]. Note: some states require [NUMBER] witnesses, some accept a notary instead of witnesses, and some require both.

13. Disclaimer

This template is provided for general informational purposes only and is not legal or medical advice. Advance directives are creatures of state law, and states differ on the required number and eligibility of witnesses, whether notarization is required or optional, whether artificial nutrition and hydration must be addressed separately, how pregnancy affects the document, and whether a state-specific statutory form must be used for providers to rely on it. Many states also offer a separate portable medical order such as a POLST or MOLST form that carries more immediate weight with emergency responders than a living will does. Review this document with your physician and, where the stakes warrant it, a licensed attorney in your state. Use of this template does not create an attorney-client relationship with ScanContract.