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I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort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 this declaration**.)

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

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

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my Health Care Representative appointed un IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5. Copy of Health Care Representative attached.

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 decision.

SIGNATURE: _____ DATE OF BIRTH:_____

PRINTED NAME: _____

ADDRESS: _____

_____

The declarant is personally known to me, and I believe (him/her) 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 am at least eighteen (18) years of age.

WITNESS:_____ DATE:_____

WITNESS:_____ DATE:_____

Reid Health Room:_____
Richmond, IN 47374 (765) 983-3000

**LIVING WILL DECLARATION**

MR0015

PATIENT LABEL