LIVING WILL

I, _____, of _____, being of sound mind, do hereby willfully and voluntarily make known my desire that my life not be prolonged under any of the following conditions, and do hereby further declare:

1. If I should, at any time, have an incurable condition caused by any disease or illness, or by any accident or injury, and be determined by any two or more physicians to be in a terminal condition whereby the use of "heroic measures" or the application of life-sustaining procedures would only serve to delay the moment of my death, and where my attending physician has determined that my death is imminent whether or not such "heroic measures" or life-sustaining measures are employed, I direct that such measures and procedures be withheld or withdrawn and that I be permitted to die naturally.

2. In the event of my inability to give directions regarding the application of life-sustaining procedures or the use of "heroic measures", it is my intention that this directive shall be honored by my family and physicians as my final expression of my right to refuse medical and surgical treatment, and my acceptance of the consequences of such refusal.

3. I am mentally, emotionally and legally competent to make this directive and I fully understand its import.

4. I reserve the right to revoke this directive at any time.

5. This directive shall remain in force until revoked.

IN WITNESS WHEREOF, I have hereto set my hand and seal this _____ day of _____, 20___.

Signed: _____

Declaration of Witnesses

The declarant is personally known to me and I believe him to be of sound mind and emotionally and legally competent to make the herein contained Directive to Physicians. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate upon his decease, nor am I an attending physician of the declarant, nor an employee of the attending physician, nor an employee of a health care facility in which the declarant is a patient, nor a patient in a health care facility in which the declarant is a patient, nor am I a person who has any claim against any portion of the estate of the declarant upon his death.

Signed: _____

STATE OF _____)
: ss.
COUNTY OF _____)

Subscribed, sworn to, and acknowledged before me by _____, the testator, and subscribed and sworn to before me by _____ witness, this ____ day of _____, 20__.

_____
Notary Public
Residing at_____
My commission expires_____