Patient Name: ____________________________

DOB: ___________________________________

LIVING WILL DECLARATION

If I should lapse into a vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

Other instructions: ____
____
____
____

Signed this __________ day of ________________, __________

____
Signature

____
Address

____
City & State

This must be witnessed by two witnesses or a Notary Public

The declarant voluntarily signed this writing in my presence; we are not the principal's spouse, parent, child, grandchild, sibling, presumptive heir, attending physician, or employee of life or health insurance provider.

Witness ________________________

Address ________________________

City/State ______________________

Witness ________________________

Address ________________________

City/State ______________________

STATE OF NEBRASKA
COUNTY OF ______________________

The declarant voluntarily signed this writing in my presence.

____Notary Public