

LIVING WILL DECLARATION

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment.

- I () Do () Do Not want Cardiopulmonary Resuscitation – CPR
- I () Do () Do Not want Mechanical Ventilation – Ventilator
- I () Do () Do Not want Tube Feedings or any other artificial means of nutrition
- I () Do () Do Not want IV Fluids for hydration
- I () Do () Do Not want Blood or Blood Products
- I () Do () Do Not want any form of Surgery or Invasive Diagnostic testing
- I () Do () Do Not want Kidney Dialysis
- I () Do () Do Not want Antibiotics

Name (print) _____ Birthdate _____

Address _____ City _____ State _____

Signature _____ Date _____ Year _____

THIS MUST BE WITNESSED BY TWO WITNESSES OR A NOTARY PUBLIC
As a witness, I declare that I am over 18 yrs of age, and not related by blood, marriage or adoption.

1 Witness _____

2 Witness _____

Address _____

Address _____

City/State _____

City/State _____

OR

Notarization:

Subscribed and affirmed before me in the county of *PHELPS*, state of *NEBRASKA*, this ____ day of _____, 20_____.

Notary's Signature

Commission Expiration Date

