LIVING WILL (Sample 1)

Made at ....

Dated this .... day of ....

Name : …………………………………………………………………………… Age: ……..

Identification number: ………………………………………………………………………

Address: ……………………………………………………………………………………

Telephone number: Home ……………………………………Mobile………………………
Office…………………………………………………………………………………………..

I, being of sound mind, **willfully and voluntarily** state my wish that medical practitioners who are responsible for my health care provide me with medical care and treatment in order to permit an acceptable quality of life.

Should I suffer any of the following conditions (those items checked with my signature) – which indicate the terminal phase of illness or injury – I do not wish to remain in such a condition:

Permanent unconscious condition: I become totally unaware of people or surroundings, with little chance of ever waking from the unconscious condition (coma).	☐ …………
Permanent confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones, or cannot have a clear conversation with them.	☐ …………
Dependent in all activities of daily life: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking, and reach a condition where rehabilitation or any other restorative treatment will not help.	☐ …………
End-stage illness: I have an illness that has reached its final stages in spite of full medical treatment – for example: widespread cancer that no longer responds to treatment; chronically diseased and/or damaged heart and lungs, where oxygen is required most of the time and physical activities are limited due to a feeling of suffocation.	☐ …………

I wish to be medically treated as follows (checking "Yes" with my signature means that I want the treatment; checking "No" with my signature means that I do not want the treatment):

1. **Cardiopulmonary resuscitation (CPR).** To cause the heartbeat to restart and to restore breathing after it has stopped. Usually this involves electric shock, chest compressions and breathing assistance.	Yes …………….. No ………………
2. **Life support or other artificial support.** Continuous use of a breathing machine, IV fluids or other medications or equipment that help the lungs, heart, kidneys and other vital organs to continue to function.	Yes …………….. No ………………
3. **Treatment of new complications.** Use of surgery, blood transfusions or antibiotics or other treatments that will deal with a new condition but will not relieve or cure the primary illness.	Yes …………….. No ………………
4. **Tube feeding.** Use of tubes to deliver food and water to the stomach, or delivery of IV fluids into a vein, which would include artificially delivered nutrition and hydration into an artery.	Yes …………….. No ………………

Where some medical treatments or procedures have been provided by public health professionals without their knowing the contents of my living will or my wishes, I call upon such professionals to withdraw medical treatment and the procedures mentioned above.

I call upon health care providers or public health professionals to abide by my decision where feasible and appropriate as follows:

- ☐ To die at home.
- ☐ To provide spiritual healing or comfort (please specify, for example, listening to reading or chanting by a priest or monk). ………………………………………………………………………………
- ☐ …………………………………………………………………………….
- ☐ ………………………………………………………………………………

I designate (name) ……………………………………………………... …………

my ………………… (spouse, child, relative, friend, …….) as my proxy to act on my behalf when I cannot communicate with other persons. My proxy will explain my true wishes or advise public health professionals about my advance care planning.

I sign this document voluntarily, and I make it upon witness. I also make a copy to be held by my proxy and witness in order that they may inform medical professionals and health care staff about the living will when I am admitted (to a health care facility).

Signed .... …

Proxy ....

Witness ....

Witness ....

Person typing or writing this document ....

Proxy (a person [such as a parent, spouse, child, relative, friend or other person of trustworthiness and with a close relationship to the patient] who may explain the true wishes of the person making the living will, or who is designated to consult with the attending medical practitioners).

Name: ……………………………………………….. Relation: ………………………….

Identification number: ………………………………………………………………………

Address: ……………………………………………………………………………………

Telephone number: ………………………………………………………………………….

Witness 1

Name: …………………………………………………. Relation: ………………………….

Identification number: ………………………………………………………………………

Address: ……………………………………………………………………………………

Telephone number: …………………………………………………………………………

Witness 2

Name: ……………………………………………….. Relation: ………………………….

Identification number: ……………………………………………………………………...

Address: ……………………………………………………………………………………

Telephone number: …………………………………………………………………………

Person typing or writing this document

Name: ………………………………………………… Relation: ………………………….

Identification number: ………………………………………………………………………

Address: ……………………………………………………………………………………

Telephone number: …………………………………………………………………………

LIVING WILL (Sample 2)

Made at ....

Dated this …. day of ....

Name: ……………………………………………………………………….. Age: ……..

Identification number: ………………………………………………………………………

Address: ………………………………………………………………………………………

Telephone number: Home……………………………………Mobile………………………

Office ………………………………………………………………………………………

I, being of sound mind, **willfully and voluntarily** state my desire to die naturally and do not wish to undergo life-sustaining treatment that serves only to prolong the process of dying, with its attendant burdens and expenses. I wish to be provided with symptomatic care in the following circumstances:

- I am in the terminal phase of illness.
- I am suffering with an incurable condition caused by injury or disease.

If I am in the condition(s) described above, I feel especially strongly about the following forms of treatment (Able to select more than one item and those selected items checked with my signature):

- ☐ I do not want tracheostomy
- ☐ I do not want mechanical ventilation.
- ☐ I do not want artificial nutrition and hydration.
- ☐ I do not wish to die in an intensive care unit (ICU).
- ☐ I do not want resuscitation (DNR).
- ☐ I do not want cardiac resuscitation.
- ☐ I do not want medical or other - treatments of complications.
- ☐ ……………………………………………………………………………..
- ☐ ……………………………………………………………………………..
- ☐ ……………………………………………………………………………..

Where these medical treatments or procedures have been provided by public health professionals without their knowing the content of my living will or my wishes, I call upon such professionals to withdraw such medical treatments or procedures.

I call upon the health care providers or public health professionals to abide by my decision where feasible and appropriate as follows:

- ☐ I do not want mechanical ventilation.
- ☐ I do not want artificial nutrition and hydration.
- ☐ …………………………………………………………………………………
- ☐ …………………………………………………………………………………
- ☐ …………………………………………………………………………………

I call upon the health care providers or public health professionals to abide by my decision where feasible and appropriate as follows:

- ☐ To die at home.
- ☐ To provide spiritual healing or comfort (please specify, for example, listening to reading or chanting by a priest or monk).
- ☐ …………………………………………………………………………………
- ☐ …………………………………………………………………………………
- ☐ …………………………………………………………………………………

I designate (name) ……………………………………….. my ………………… (spouse, child, relative, friend, …….) as my proxy to act on my behalf when I cannot communicate with other persons. My proxy will explain my true wishes or advise public health professionals about my advance care planning.

I sign this document voluntarily, and I make it upon witness. I also make a copy to be held by my proxy and witness in order that they may inform medical professionals and health care staff about the living will when I am admitted (to a health care facility).

Signed ....

Proxy ....

Witness ....

Witness ....

Person typing or writing this document ....

Proxy (a person [such as a parent, spouse, child, relative, friend or other person of trustworthiness and with a close relationship to the patient] who may explain the true wishes of the person making the living will, or who is designated to consult with the attending medical practitioners).

Name: ……………………………………………….. Relation: ………………………….
Identification number: ……………………………………………………………………….
Address: ………………………………………………………………………………………
Telephone number: ……………………………………………………………………..

Witness 1

Name: ………………………………………………..… Relation: ………………………….
Identification number: ……………………….…………………………..………………
Address: ………………………………………………………………………………………
Telephone number: ……………………………………………………………..……….

Witness 2

Name: ………………………………………………… Relation: …………………………..
Identification number: ……………………………………………………………………..
Address: ………………………………………………………………………………………
Telephone number: ………………………………………………………………………

Person typing or writing this document

Name: …………………………………………………... Relation: ………………………….
Identification number: ……………………………………………………………………...
Address: …………………………………………………………………………………..…
Telephone number: ………………………………………………………………………