# Living Will Worksheet

*\_\_\_\_\_* ***1. Terminal Condition.***

*If I should have an incurable or irreversible condition which has been certified as a terminal condition that will cause my death within a relatively short time by my attending physician and on additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition and my death is imminent, and where the application of life prolonging procedures would serve only to artificially prolong the dying process, and are not necessary to my comfort, care, or to alleviate pain, then this authorization includes, but is not limited to, the* ***withholding or the withdrawal of the following types of medical treatment*** *(subject to special instructions in Paragraph 7 below) :*

*\_\_\_\_\_*  ***A.*** *Artificial feeding and hydration.*

*\_\_\_\_\_* ***B.*** *Cardiopulmonary resuscitation ( this includes but not limited to, the use of drugs, electric shock, and artificial breathing).*

*\_\_\_\_\_* ***C.*** *Kidney dialysis.*

*\_\_\_\_\_* ***D.*** *Surgery or other invasive procedures.*

*\_\_\_\_\_* ***E.*** *Drugs and antibiotics.*

*\_\_\_\_\_* ***F.*** *Transfusions of blood or blood products.*

*\_\_\_\_\_* ***G.*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*\_\_\_\_\_* ***2. Irreversible Coma or Persistent Vegetative State.***

*If I should be in an irreversible coma or persistent vegetative state which has been certified as incurable by my attending physician and one additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition and my death is imminent, and where the application of life prolonging procedures would serve only to artificially prolong the dying process, and are not necessary to my comfort, care, or to alleviate pain, then this authorization includes, but is not limited to, the* ***withholding or the withdrawal of the following types medical treatment*** *(subject to any special instructions in Paragraph 7 below) :*

*\_\_\_\_\_* ***A.*** *Artificial feeding and hydration.*

*\_\_\_\_\_* ***B.*** *Cardiopulmonary resuscitation ( this includes,* ***but is not limited to, the use of drugs, electric shock, and artificial breathing****).*

*\_\_\_\_\_* ***C.*** *Drugs and antibiotics.*

*\_\_\_\_\_* ***D.*** *Surgery or other invasive procedures.*

*\_\_\_\_\_* ***E.*** *Kidney dialysis.*

*\_\_\_\_\_*  ***F.*** *Transfusion of blood or blood products.*

*\_\_\_\_\_* ***G.*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*\_\_\_\_\_* ***3. Medical Condition Where I Cannot Communicate.***

*If I have a medical condition where I am unable to communicate my desires as to treatment, and my physician determines that the burdens of treatment outweigh the expected benefits, I direct my attending physician to withhold or withdraw treatment other than the medical procedures and treatment necessary for my comfort or to alleviate pain. This authorization includes, but is not limited to, the* ***withholding or withdrawal of the following types medical treatment*** *(subject to any special instructions in paragraph 7 below):*

*\_\_\_\_\_* ***A.*** *Artificial feeding and hydration.*

*\_\_\_\_\_* ***B.*** *Cardiopulmonary resuscitation ( this includes, but is not limited to, the use of drugs, electric shock, and artificial breathing).*

*\_\_\_\_\_* ***C.*** *Kidney dialysis.*

*\_\_\_\_\_*  ***D.*** *Surgery or other invasive procedures.*

*\_\_\_\_\_* ***E.*** *Drugs and antibiotics.*

*\_\_\_\_\_* ***F.*** *Transfusions of blood or blood products.*

*\_\_\_\_\_* ***G.***  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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*\_\_\_\_\_* ***4. Life Prolonged.***

*I want my life prolonged to the greatest extent possible ( subject to any special instructions in paragraph 7 below).*

*\_\_\_\_\_* ***5. Pregnancy.***

*If I am diagnosed as pregnant, this document shall have no force and effect during my pregnancy.*

*\_\_\_\_\_* ***6. Durable Power of Attorney for Healthcare.***

*If I have also signed a Durable Power of Attorney for Healthcare, Appointment of Healthcare Agent, or Healthcare Proxy, I direct the person who I have* ***appointed with such instrument to follow the directions that I have made in this document.***

*\_\_\_\_\_* ***7. Additional Directions.***

*I have the following additional directions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_* ***8. Limitations on Decision – Makers.***

*I DO NOT want the following person(s) to be involved in any manner in the decision-making regarding my medical treatment, or the withholding or withdrawal of medical treatment : \_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*