LIVING WILL DECLARATION

I, _____, a resident of the State of Indiana, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1)1 have an incurable injury, disease, or illness; and (2) my death will occur within a short time; and (3) the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain and if I have so indicated below, the provision of:

Artificially supplied nutrition and hydration. ***(Indicate your choice by initializing, before signing this declaration):***

_____**I wish to** receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ **I do not wish** to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____**I intentionally make no** decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC *30-5-5.*

Organ donation. ***(Indicate your choice by initialing, before signing this declaration):***

_____ **I wish to donate organs upon** my death as follows:

_____

_____ .

_____**I wish to donate organs** upon my death as deemed necessary by my physician.

_____**I do not wish to donate organs upon** my death.

_____**I intentionally make no decision concerning the issue of donating organs upon** my death, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC ***30-5-5.***

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this Declaration be honored by my family, physician, and any health care facilities in which I am a patient as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of my refusal as I have.

I authorize the delivery of this declaration to any physician and health care facility that may provide medical treatment to me and authorize any physician having custody of this document to release any needed medical information and to deliver any documents and information to any person as may be necessary or desirable to accomplish my intent as expressed herein.

I understand the full import of this Declaration. I, _____, execute this document as a statement of my intent this _____ day of _____, 20__.

_____

_____, Declarant

ACKNOWLEDGMENT AND VERIFICATION OF LIVING WILL

The Declarant has been personally known to me, and I believe _____ to be of sound mind. I did not sign the Declarant's signature above for or at the direction of the Declarant. I am not a parent, spouse, or child of the Declarant. I am not entitled to any part of the Declarant's estate or directly financially responsible for the Declarant's medical care. I am over the age of eighteen (18) years and competent to serve as a witness to the declarant's Living Will Declaration.

Dated this ____ day of _____, 20__.

WITNESS NAME AND ADDRESS

Witness Signature:_____

Witness Name:_____

Witness Address:

_____

_____

WITNESS NAME AND ADDRESS

Witness Signature:_____

Witness Name:_____

Witness Address:

_____

_____