MY ADVANCE TREATMENT DIRECTIVE OR "LIVING WILL"

To my family, my friends, my physicians and all others who may be interested.

I,....., request that I be fully informed of my medical condition. Whenever possible I want to participate in decisions regarding my medical treatment, including whether any measure should be taken to prolong my life. If my physicians determine I do not have the capacity to make health care decisions, this directive should be used to ascertain my decision.

In the event my physicians determine, to a reasonable degree of medical certainty, that I have an incurable and irreversible condition which will inevitably lead to my death or that I am permanently unconscious, I direct that I NOT be provided medical treatment which serve only to prolong my dying or continue my unconscious state. IN such an event, I DO want those measures which will keep me comfortable and relieve pain, even if they will render me unconscious or hasten my death.

I especially do NOT want he following forms of treatment when they would only prolong my dying or continue my unconscious state:

(1) cardiopulmonary resuscitation (CPR)
(2) mechanical ventilation support beyond 48 hours.
(3) nutrition and hydration by artificial means.
(4) chemical or radiation treatment for cancer.
(5) organ replacement surgery.

Other Instructions:

1. If I am diagosed "BRAIN DEAD" please discontinue and cease all life support treatment immediately, and enter a "no-code" order on my patient chart.
2. I do NOT want all the technological benefits health care can provide but I DO want good patient care aimed at preventing pain and discomfort.
3. Primary consideration is to be given toward reducing emotional and financial trauma to my immediate family.

This directive was made after careful consideration and is in accordance with my strong convictions and beliefs. I want the directions followed to the full extent permitted by law.

I release from legal liability all persons and entities involved in the carrying out of the directions of this living WILL, and I direct my legal representative to honor this release.

Proxy Designation Clause
("Durable Power of Attorney for Health Care")

In the event I lose capacity to make health care decisions I AUTHORIZE the following persons to make those decisions on my behalf, giving priority in the order listed:

(1)

(2)

(3)

I sign this living Will and Durable Power of Attorney as my free and voluntary action, and expect that the provisions described there shall be carried out as stated.

Signed:.....
Date.....

Witnessed by:.....

Address:.....
Date:.....

Witnessed by:.....

Address:.....

Date:.....