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: ……