HEALTHCARE TREATMENT DIRECTIVE
"A LIVING WILL"

_____ _____

FULL NAME **DATE OF BIRTH**

I have the primary right to make my decisions concerning treatment that might unduly prolong my dying process. By this directive I am providing clear and convincing proof of my intent regarding my dying process to my physician, family, friends, and other concerned persons. This Healthcare Treatment Directive supersedes and cancels any of my earlier Healthcare Treatment Directives. If my physician believes that any life-prolonging procedure may lead to a significant recovery, I direct my physician to proceed with the treatment for a reasonable period of time. If the treatment does not improve my condition, I direct my physician to cease the treatment even if this cessation shortens my life.

HOWEVER, IF I SHOULD HAVE AN IRREVERSIBLE, INCURABLE, TERMINAL CONDITION OR WHEN A CONDITION, DISEASE OR INJURY EXISTS AND THERE IS NO HOPE OF A SIGNIFICANT RECOVERY AND THERE IS NO REASONABLE EXPECTATION THAT I WILL REGAIN AN ACCEPTABLE QUALITY OF LIFE, IT IS MY DESIRE THAT MY DYING NOT BE PROLONGED AND I SPECIFICALLY DIRECT MY PHYSICIAN TO WITHHOLD OR WITHDRAW MEDICAL PROCEDURES THAT MERELY PROLONG THE DYING PROCESS AND ARE NOT NECESSARY TO MY COMFORT OR TO ALLEVIATE PAIN.

I do not intend these instructions to limit my representative's decision-making authority, but only to provide guidance. It is not my intent to authorize acts or omissions to shorten my life, rather only to permit the natural process of dying. If the **SITUATION** as set forth above were to exist, I specifically do NOT want the following life prolonging procedures:

(Please check all that apply)

- ☐ **CPR (HEART LUNG RESUSCITATION)**
- ☐ **RESPIRATOR (MECHANICAL VENTILATOR)**
- ☐ **SURGICAL PROCEDURES**
- ☐ **DIALYSIS**
- ☐ **ANTIBIOTICS**
- ☐ **BLOOD TRANSFUSIONS**
- ☐ **TUBE FEEDINGS EITHER THROUGH THE NOSE, STOMACH, OR INTRAVENOUSLY**

(Please check one or the other)

☐ I want to donate my organs or tissues and realize it may be necessary to maintain my body artificially after my death on a breathing machine until my organs can be removed.

☐ I do NOT want to donate my organs or tissues.

OTHER DIRECTIONS: _____

_____ _____

Signature **Date**

_____ _____

Signature of Witness Address

_____ _____

Signature of Witness Address

On this _____ day of _____, before me personally appeared the aforesaid Declarant and Witnesses who are known to be the persons described in the above document; executed this document; declared that they signed the document willingly and voluntarily for the purposes expressed therein; and all affirmed that the Declarant was of sound mind and under no constraint or undue influence.

My Commission Expires:

_____

Notary Public

PHOTOCOPIES OF THIS DOCUMENT SHOULD BE TREATED AS IF THEY WERE ORIGINALS

BEARD LAW FIRM, LLC 417.255.0320 Beardlaw@beardlaw.com