**LIVING WILL (ADVANCE DIRECTIVE)**

*(Valid across all U.S. states – Check local laws for specific requirements)*

**1. DECLARATION OF INTENT**

I, **[Full Name]**, residing at **[Address]**, being of sound mind and acting voluntarily, make this **Living Will** to state my preferences for medical care if I become unable to make decisions for myself.

I direct that my healthcare providers, family members, and appointed **Health Care Agent (if any)** follow my instructions as set forth in this document.

**2. CONDITIONS FOR ACTIVATION**

This Living Will **takes effect** if I am:

☐ In a **terminal condition**, with no reasonable expectation of recovery.
☐ In a **permanent coma** or **persistent vegetative state**, with no reasonable chance of regaining consciousness.
☐ Suffering from an **incurable or irreversible condition** that causes severe suffering or loss of dignity.
☐ Other: **[Specify]**

**3. TREATMENT PREFERENCES**

**A. Life-Sustaining Treatments**

If I am in a **terminal condition, irreversible coma, or persistent vegetative state**, I **do not want** life-prolonging treatments, including but not limited to:

☐ **Mechanical ventilation** (breathing machines)
☐ **Artificial nutrition and hydration** (feeding tubes, IV fluids)
☐ **CPR (cardiopulmonary resuscitation)**
☐ **Dialysis** (if my kidneys fail)
☐ **Surgery or invasive procedures**
☐ **Antibiotics or aggressive medications to prolong life**
☐ **Other:** **[Specify]**

☐ **I wish to receive all available treatments to prolong my life, regardless of my condition.**

**B. Pain Management & Comfort Care**

I want to receive **palliative (comfort) care** to **relieve pain and suffering**, even if it shortens my life.

☐ **I want the maximum pain relief available.**
☐ **I want moderate pain relief but do not wish to be sedated.**
☐ **Other preferences:** **[Specify]**

**C. Do Not Resuscitate (DNR) Order *(Optional – consult your doctor for a state-specific DNR form)***

☐ **I do NOT want CPR or other resuscitative measures if my heart stops.**
☐ **I DO want all resuscitative measures, including CPR, defibrillation, and emergency intervention.**

**4. ORGAN AND TISSUE DONATION (OPTIONAL)**

☐ **I wish to donate any needed organs/tissues upon my death.**
☐ **I wish to donate only the following organs/tissues:** **[Specify]**
☐ **I do not wish to donate any organs/tissues.**
☐ **I leave this decision to my agent or family.**

**5. APPOINTMENT OF HEALTH CARE AGENT (IF NOT ALREADY DESIGNATED IN A HEALTH CARE PROXY)**

If I have not completed a separate **Health Care Proxy**, I appoint:

**Health Care Agent Name:** **[Full Name]**
**Address:** **[Address]**
**Phone:** **[Phone]**

as my **Health Care Agent** to make medical decisions on my behalf if I am unable to do so.

☐ **I do not wish to appoint a Health Care Agent.**

**6. ADDITIONAL INSTRUCTIONS (OPTIONAL)**

Use this section to specify any additional medical preferences, religious considerations, or special instructions.

Example: "I do not want blood transfusions due to religious beliefs."

☐ **Attach additional pages if necessary**

**7. SIGNATURE & ACKNOWLEDGMENT**

I declare that this **Living Will** reflects my healthcare preferences and is made voluntarily.

**Your Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Your Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Your Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. WITNESSES**

*(Must be signed by two adult witnesses who are NOT your appointed health care agent or direct beneficiaries.)*

**Witness 1**

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness 2**

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. NOTARY ACKNOWLEDGMENT (OPTIONAL, REQUIRED IN SOME STATES)**

This acknowledgment is **part of the Living Will document** signed by **[Your Name]** on **[Date]**, consisting of **[Number]** pages.

**STATE OF [Your State]**
**COUNTY OF [Your County]**

On this \_\_\_ day of \_\_**, 20**, before me, a Notary Public, personally appeared **[Your Name]**, known to me or proven by satisfactory evidence to be the person who signed this document, and acknowledged that they executed it voluntarily.

**Notary Public Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Notary Public Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**My Commission Expires:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_