

**SAMPLE LIVING WILL DECLARATION**

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_. I, \_\_\_\_\_,  
residing in the City of \_\_\_\_\_, County of \_\_\_\_\_, State of \_\_\_\_\_  
\_\_\_\_\_, being at least eighteen (18) years of age and of sound mind, wilfully 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) I have an incurable, injury, disease, or  
illness; (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withdrawn and that I be permitted to die naturally with only the performance or provision of any  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 initialling or making your mark 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.

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 and physician as the final expression of my legal  
right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

\_\_\_\_\_  
(signature)

The declarant has been known to me personally and I believe him or her 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 declarant's medical care. I am competent and at least eighteen (18) years of age.

Dated: \_\_\_\_\_ Witness One: \_\_\_\_\_

Dated: \_\_\_\_\_ Witness Two: \_\_\_\_\_