

Living Will

for both Missouri and Kansas

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, subject to later revocation, and do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, and I am unable to participate in decisions regarding my medical treatment, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort.

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally capable to make this declaration.

This declaration is made this _____ day of _____ 20_____

- I do not wish to make additional instructions.
- My additional instructions are listed on the reverse side.

Declarant _____

The declarant has been personally known to me and I believe the declarant to be of sound mind and 18 years or older. The declarant voluntarily signed this document in my presence. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, am not entitled to any portion of the estate of the declarant either as a legal heir or under any Will of declarant or any addition thereto, and am not directly financially responsible for declarant's medical care.

Witness _____

Address _____

Witness _____

Address _____

Optional Additional Instructions

For any provision below that is NOT applicable to you, draw a line through it and add your initials.

Even if some of the following optional instructions are deemed not be valid under Kansas statute, the following is a statement of my treatment wishes which I would like, for all those considering my course of treatment, to be as clear and convincing evidence of my treatment wishes. If I lack the capacity to make or communicate decisions regarding medical treatment and there is no reasonable expectation that I will regain a meaningful quality of life, it is my desire that the following statements be taken into consideration:

- I direct all life-sustaining procedures to be withheld or withdrawn if I have:
 - a terminal condition, or
 - a condition, disease or injury without hope of significant recovery, or
 - extreme mental deterioration, or
 - other _____
- Life-sustaining procedures I choose to have withheld or withdrawn include:
 - surgery
 - heart-lung resuscitation (CPR)
 - antibiotics
 - mechanical ventilator (respirator)
 - tube feeding (food and water delivered through a tube in the vein, nose or stomach)
 - other _____
- If my physician believes that a certain life-sustaining procedure or other medical treatment may provide me with comfort, relieve pain or lead to significant recovery, I direct my physician to try the treatment for a reasonable period of time. If it does not improve my condition, provide comfort and relieve pain, I direct the treatment be withdrawn, even if so doing shortens my life.
- I direct I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.
- A meaningful quality of life means to me that: (This does not need to be filled in or the instructions to be valid.)

- I prefer to live out my last days at home rather than in a hospital or nursing home if it is not a burden to my family.
- If any of my tissues or organs would be of value as transplants to help other people, I freely give my permission for such donation.
- I make other instructions as follows: _____

- I have discussed my wishes with the following person(s) and request my physician to discuss my treatment decisions with them:
Name _____ Telephone _____
Address _____
Name _____ Telephone _____
Address _____
- I have read these instructions and have given them careful consideration, and as I have indicated, they are in accordance with my wishes.
Date _____ Declarant Signature _____
Witness _____ Witness _____

Discuss this document with your physician(s), family members, friends and clergy, and provide them with a signed copy or photocopy.