STATUTORY LIVING WILL DECLARATION

Declaration made this _____ day of _____, 20___.

I, _____, date of birth _____, of _____ (city), _____ (county), and _____ (state), 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life-sustaining procedures would only serve to prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me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 care.

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

I understand the full significance of this declaration, and I am emotionally and mentally competent to make this declaration.

❒ I do not wish to make additional instructions.

❒ My additional instructions are listed on the reverse side (or page 2) of this form.

Signature of Declarant _____
(May be signed by another person in the declarant's presence and by the declarant's expressed direction.)

This document must be signed in the presence of two witnesses **OR** acknowledged by a notary public.

By signing below, I certify the following: 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.

(1) Witnesses – two individuals of lawful age who are not the agent; not related to the principal by blood, marriage, or adoption; not entitled to any portion of the principal's estate; and not financially responsible for principal's health care.

Witness _____ Witness _____

Address _____ Address _____

OR

(2) STATE OF KANSAS)
) ss:
COUNTY OF _____)

This instrument was acknowledged before me on this _____ day of _____, 20___.

Signature of Notary Public _____

My appointment expires: _____

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

OPTIONAL ADDITIONAL INSTRUCTIONS

In addition to the above and foregoing, all persons involved in decisions regarding my medical treatment shall consider the following as clear and convincing evidence of my treatment wishes in the event I lack the capacity to make or communicate decisions regarding my health care treatment and there is no realistic hope that I will regain such capacity:

If there is no reasonable hope that I will regain a meaningful quality of life and I have:

- a terminal condition;
- a condition, disease, or injury without reasonable expectation of significant recovery;
- substantial brain damage or brain disease, or extreme mental deterioration including dementia; or
- other _____, then I direct that life-saving or life-prolonging measures or procedures be administered or withheld/withdrawn in accordance with my instructions marked below:

When any of the conditions described in the preceding paragraph exist, I request that I be provided all of the following measures or interventions ***EXCEPT*** those that I have marked "**No**."

Yes	**No**	SURGERY	**Yes**	**No**	DIALYSIS
Yes	**No**	HEART-LUNG RESUSCITATION (CPR)	**Yes**	**No**	ANTIBIOTICS
Yes	**No**	MECHANICAL VENTILATOR (respirator requiring intubation)	**Yes**	**No**	TUBE FEEDING (food and water delivered through tube in the veins, nose, or stomach)
Yes	**No**	OTHER _____	**Yes**	**No**	OTHER _____

Yes **No** If my physician believes that any life-saving or life-prolonging measure or intervention may lead to a significant recovery (even those marked "No" above), I direct my physician to try the treatment for a reasonable period of time. If it does not significantly improve my condition, I direct the treatment be withdrawn, even if so doing shortens my life.

Yes **No** I direct that in all circumstances, I be given health care treatment to relieve pain or provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

I consider a "meaningful quality of life" to include the following, which shall be taken into consideration by any caregivers and/or surrogate decision makers in determining my course of medical treatment: _____
_____
_____
_____

I make other instructions as follows: _____
_____
_____

Signature of Declarant _____
(May be signed by another person in the declarant's presence and by the declarant's expressed direction.)

(1) Witness _____ Witness _____

Address _____ Address _____

OR

(2) STATE OF KANSAS)
) ss:
COUNTY OF _____)

This instrument was acknowledged before me on this _____ day of _____, 20___.

Signature of Notary Public _____

My appointment expires: _____

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