

The **LIVING WILL DECLARATION** of

Resident Name: _____

This LIVING WILL OF DECLARATION made this _____ Day of _____, by
_____.

The undersigned declarant, whose resident address is The Pines Assisted Living Home.

WITNESSETH: That I, the undersigned declarant, being of sound mind, willfully and voluntarily make known my desires concerning my health care options below:
(Pursuant to A.R.S _36-3262, some general statements concerning your health care options are outlined below. If you agree with one of these statements, you should initial that statement on that statement on the line provided. Read al of these statements carefully before you initial your selection. You can also write your own statement concerning life sustaining treatment and other matters relating to your health care. You may Initial any combination of paragraphs 1,2,3, and 4 but if you initial paragraph 5, the others should not be Initialed)

_____ **1.** If I have a terminal condition, I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

_____ **2.** If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following:

- _____ (a) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing.
- _____ (b) Artificially administered foods and fluids.
- _____ (c) To be taken to hospital if at all avoidable.

_____ **3.** Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ **4.** Notwithstanding my other directions, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____ **5.** I want my life to be prolonged to the greatest extent possible.

Other or Additional Statement of Desires (Attached Separate Sheet)

I have _____ I have not _____ attached additional special provisions or limitations to this document to be honored In the absence of my being able to give health care directions.

Any person honoring this LIVING WILL DECLARATION, whether a family member, a next friend, the attending physician; the health care institution and/or any licensed health care professional shall not incur any liabilities of any nature whatsoever in discharging those duties imposed by this LIVING WILL DECLARATION.

IN WITNESS WHEREOF, I, the undersigned Declarant, do hereby make and execute this LIVING WILL DECLARATION on the date first above written; that I understand the full importance of this Declaration, and I have the emotional and mental capacity to make this Declaration.

Signature of Declarant: _____

Witness Statement

The Declarant Is personally known to me; that I believe him/her to be Sound mind; that I am not related to the Declarant either by blood or marriage; that I am 18 years of age or older, that at the time of Declarant's execution of this Declaration, I am not entitled to any portion of the Declarant's estate under either a will, codicil to a will, or by the operation of Law, that I am not a claimant against any portion of the Declarant's estate; that I have no direct financial responsibility for the Declarant's medical care.

Witness 1

Signature of Witness 1: _____ Date: _____

Printed Name: _____

Address: _____

City/State/Zip Code: _____

Witness 2

Signature of Witness 2: _____ Date: _____

Printed Name: _____

Address: _____

City/State/Zip Code: _____