HEALTHCARE DIRECTIVE

Directive made this _____ day __________, year _______

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, and do
hereby declare that:

A. If at any time I should have an incurable and irreversible condition
certified to be a terminal condition by my attending physician, and
where the application of life-sustaining treatment would serve only to
artificially prolong the process of my dying, I direct that such
treatment be withheld or withdrawn, and that I be permitted to die
naturally. I understand "terminal condition" means an incurable and
irreversible condition caused by injury, disease, or illness that
would, within reasonable medical judgment, cause death within a
reasonable period of time in accordance with acceptable medical
standards.

B. If I should be in an irreversible coma or persistent vegetative state,
or other permanent unconscious condition, as certified by two
physicians, and from which those physicians believe that I have no
reasonable probability of recovery, I direct that life-sustaining
treatment be withheld or withdrawn.

C. If I am diagnosed to be in a terminal or permanently unconscious
position, I want ____ or I do not want ____ artificially administered
nutrition or hydration to be withdrawn or withheld the same as other
forms of life-sustaining treatment. I understand artificially
administered nutrition and hydration is a form of life-sustaining
treatment in certain circumstances. I request all healthcare providers
who care for me to honor this directive.

D. In the absence of my ability to give directions regarding the use of
such life-sustaining procedures, it is my intention that the directive
shall be honored by my family, my physicians, and other healthcare
professionals as the final expression of my fundamental right to refuse
medical or surgical treatment, and also honored by any person appointed
to make these decisions for me, whether by durable power of attorney or
otherwise. I accept the consequences of such refusal.

E. If I have been diagnosed as pregnant and that diagnosis is known to my
physician, this directive shall have no force or effect during the
course of my pregnancy.

F. I understand the full import of this directive and I am mentally and
emotionally competent to make this directive. I also understand that I
may amend or revoke this directive at any time.
G.
I make the following additional directions regarding my care:

__________________________
__________________________
__________________________
__________________________
__________________________
__________________________
__________________________

Signed.
:

The declarer has been personally known to me and I believe him or her to be of sound mind. In addition, I am not the attending physician or health facility in which the declarer's is a patient, or any person who has a claim against any portion of the estate of the declarer upon the declarer's decease at the time of the execution of the directive.

Witness:

Witness:

Witness: