NEW YORK LIVING WILL

I, _____, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below.

I direct my attending physician and other medical personnel to withhold or withdraw treatment that serves only to prolong the process of my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery. These instructions apply if I am: a) in a terminal condition; b) permanently unconscious; or c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that my treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

While I understand that I am not legally required to be specific about future treatments, if I am in the condition(s) described above, I feel especially strong about the following forms of treatment to be withheld as indicated by a check mark (✓).

❑ I do not want cardiac resuscitation.

❑ I do not want mechanical respiration.

❑ I do not want tube feeding, artificial nutrition and hydration.

❑ I do not want antibiotics.

❑ I do want maximum pain relief, even if it may hasten my death.

❑ Other instructions (insert personal instructions):

_____

_____

_____

_____

These directions express my legal right to refuse treatment, under the laws of New York. Unless I have revoked this instrument or otherwise clearly and explicitly indicated that I have changed my mind, it is my unequivocal intent that my instructions as set forth in this document be faithfully carried out.

Signed: _____ Date: _____

Address: _____

[YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES]

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness #1: _____

Signed: _____

Address: _____

Witness #2: _____

Signed: _____

Address: _____

KEEP THIS SIGNED ORIGINAL WITH YOUR PERSONAL PAPERS AT HOME. GIVE COPIES OF THE SIGNED ORIGINAL TO YOUR DOCTOR, FAMILY, LAWYER AND OTHERS WHO MIGHT BE INVOLVED IN YOUR CARE.