Declaration made this _____ day of _____, 20_____

I,_____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that if at any time I am incapacitated and (initial the conditions that apply)

_____ I have a terminal condition;

_____ I have an end-stage condition;

_____ I am in a persistent vegetative state

and, if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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 or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide expressed and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

NAME: _____

ADDRESS: _____

STATE: _____ ZIP CODE: _____

PHONE ( ) _____ PHONE ( ) _____

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

Additional instructions (optional): _____

_____

_____

_____

Declarant Signature:_____

This declaration was signed by the declarant in the presence of the following two witnesses, one of whom is neither a spouse nor blood relative.

Witness: _____

Address: _____

Phone: ( ) _____ Date: _____

Witness: _____

Address: _____

Phone: ( ) _____ Date: _____

SARASOTA MEMORIAL HOSPITAL

LIVING WILL DECLARATION

027075 Rev. 08/12

DON'T FORGET TO LABEL ALL COPIES. IF NO LABEL, MUST INDICATE PATIENT NAME, DATE OF BIRTH AND DOCTOR
PATIENT NAME
DATE OF BIRTH
DOCTOR:
PLACE PATIENT ID LABEL HERE