LIVING WILL

DECLARER NAME: **«PRINCIPAL_NAME»**

DATED**:** _____

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LIVING WILL

KNOW ALL PEOPLE by these presents that I, **«PRINCIPAL_NAME»**, of the County of «County_Principal_Resides», State of New York, hereby declare my will with respect to my medical care and treatment in the event I am unable for any reason to make known my will at the time medical decisions must be made.

1. Directive not to use or to discontinue life-prolonging medical treatment when recovery is unlikely.

In the event I suffer from an injury, disease, illness or other physical or mental condition which renders me unable to make medical decisions on my own behalf, which leaves me unable to communicate with others meaningfully, and from which there is no reasonable prospect of recovery to a cognitive and sentient life, I direct that no medical treatments or procedures be utilized in my care or, if begun, that they be discontinued.

2. Definition of medical treatment.

By "medical treatments or procedures", I mean interventions by medical doctors, nurses, paramedics, or any other health care provider, (including a nursing home), in the care of my body and mind, including all medical and surgical procedures, mechanical or otherwise, treatments, therapies, including drugs and hormones, which may substitute for, replace, supplant, enhance or assist any bodily function. This specifically includes maintenance of respiration, nutrition and hydration by artificial means. With respect to all medical treatments or procedures, I include both existing technology and any methods or techniques which may be hereafter developed and perfected.

3. Provision for pain control.

I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible.

4. Determination of prognosis.

My health care agent acting pursuant to my duly executed Health Care Proxy shall follow my directions as set out in this Living Will whenever they have ascertained by reasonable medical standards that my condition is as described in Section 1, above. Absent my health care agent's instructions, any other person shall comply with my directions upon certification that my condition is as described in Section 1, above, by two physicians.

5. Acknowledgment of effects of this Living Will.

I make and execute this Living Will knowing that, if complied with, my death will occur sooner than it would were all available and appropriate medical treatments considered and used. I accept this as a necessary result of a decision to avoid dependence and pain. And I make this decision now, for myself, after careful consideration, to assure that I will have the level of medical care which I want, and to relieve others of the burden of decision.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this ____ day of _____, «YEAR».

Sign Name: _____

«PRINCIPAL_NAME»

ACKNOWLEDGMENT

«PRINCIPAL_NAME», the Declarant named in the foregoing instrument, signed this instrument consisting of three (3) typewritten pages (including this attestation page), on the ___ day of _____, «YEAR». At that time, she declared that the instrument reflects her will and intent with respect to her medical care and treatment. At her request, in her presence and in the presence of each other, each of us believing her to be of sound mind, emotionally and mentally competent, we have signed our names as witnesses.

_____ residing at _____

_____

_____ residing at _____

_____