

NEW YORK LIVING WILL

This declaration is intended to serve as a guide to assist my duly appointed health care agent in making medical decisions on my behalf. However, it is not intended to limit my health care agent's sole discretion to interpret this document and to make medical decisions in good faith after full consideration of my medical condition and prognosis. If my health care agent is unable to serve for any reason, my attending physicians shall comply with my directions.

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 to withhold or withdraw treatment that merely prolongs 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) minimally conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that 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 strongly about the following forms of treatment:

I do not want cardiac resuscitation.

I do not want mechanical respiration.

I do not want tube feeding.

I do not want antibiotics.

I do want maximum pain relief.

Other directions: _____

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed: _____ Date: _____

Statement by Witnesses (*Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.*)

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.

Date: _____

Witness 1 (Signature): _____

Witness 1 (Print name): _____

Witness 1 (Address): _____

Date: _____

Witness 2 (Signature): _____

Witness 2 (Print name): _____

Witness 2 (Address): _____
