

LIFE-PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____, _____. I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition, I request the use of life prolonging procedures that would extend my life. This includes the appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

Other Instructions:

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right request medical or surgical treatment and accept the consequences of the request.

DECLARANT SIGNATURE

I understand the full import of this declaration.

(Signature)

(Date)

(Printed signature)

(Address)

(County)

(City/State/Zip)

WITNESS SIGNATURES

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness: _____ Date: _____

Witness: _____ Date: _____

(Printed Signature)

(Printed Signature)

(Address)

(Address)

Compliments of:

King's Daughters' Hospital & Health Services

P.O. Box 447, One King's Daughters' Drive
Madison, Indiana 47250