

INDIANA LIVING WILL DECLARATION

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INSTRUCTIONS

PRINT THIS DATE

PRINT YOUR NAME

INITIAL THE
STATEMENT THAT
REFLECTS YOUR
WISHES ABOUT
ARTIFICIAL FEEDING

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

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Hospice and Palliative
Care Organization
2008 Revised

**DECLARATION A
TO WITHHOLD OR WITHDRAW LIFE-PROLONGING PROCEDURES**

Declaration made this _____ day of _____.
(day) (month, year)

I, _____,
(name)

being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under Indiana Code 16-36-1-7 or my attorney in fact with health care powers under Indiana Code 30-5-5.

Other directions:

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SIGN THE DOCUMENT
AND PRINT YOUR
PLACE OF RESIDENCE

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 to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full importance of this declaration.

Signed _____

City, County, and State of Residence _____

WITNESSING
PROCEDURE

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 MUST
SIGN AND DATE
THE DOCUMENT

Witness _____

Date _____

Courtesy of Caring Connections

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