Living Will
(Advance Medical Directive)

STATE OF LOUISIANA PARISH OF ______________________________

I, ____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

1. If all of the following conditions are present, I state that the procedures checked "NO" in Paragraph 2 below should be withheld or stopped and that I should be allowed to die naturally with only the giving of medication or the doing of any medical procedure that is necessary to provide me with comfort care:

a. I have an incurable injury, disease or illness or I am in a continual deep comatose state with no reasonable chance of getting well; and

b. I have been personally examined by two physicians (at least one of whom shall be my treating physician) and both physicians certify in writing:

1. That my condition is terminal, irreversible and will likely cause my death in the near future, whether or not life-sustaining procedures are used and
2. Application of the procedures would only artificially put off the dying process, or
3. That I am in a continual deep comatose state with no reasonable chance of ever getting well.

2. I make the following directions concerning these procedures. Checking YES means I want the treatment. Checking NO means I do not want the treatment.

YES	NO	
____	____	**Cardiopulmonary Resuscitation** - using drugs and electric shock to keep my heart beating and helping me to breathe
____	____	**Mechanical Breathing** - ventilation; using a machine to help me breathe
____	____	**Major Surgery** - such as removing my gall bladder or part of my intestines
____	____	**Kidney Dialysis** - using machines to clean my blood
____	____	**Chemotherapy** - using drugs to fight cancer
____	____	**Invasive Diagnostic Tests** - such as using a tube to look into my stomach
____	____	**Artificial Nutrition and Hydration** - giving me food and fluid through a tube in my veins, nose or stomach
____	____	**Blood or Blood Products** - such as giving me a transfusion
____	____	**Antibiotics** - using drugs to fight infection
____	____	**Simple Diagnostic Tests** - such as blood tests or x-rays
____	____	**Pain Medications** - even if they make me sleepy or indirectly shorten my life

3. If I cannot give directions concerning the use of such life-sustaining procedures, I want this statement to be honored by my family and physician(s) as the last expression of my legal right to accept or refuse medical or surgical treatment and I accept the effects of such refusal.

4. I have also given a Durable Health Care Power of Attorney at the time I made this statement. In case of a disagreement between this statement and the person to whom I have given the right and power to act for me, the following statement shall come first:
(Choose one or the other and check ONLY one)
____ This statement shall come before the Durable Health Care Power of Attorney.
____ My Durable Health Care Power of Attorney shall come before this statement.

5. I understand the full importance of this statement and I am emotionally and mentally able to make this statement.

IN WITNESS HEREOF,
I have signed and acknowledged this statement on this _____day of ________________________, 20_______.

SIGNED: ____

The person signing this statement has been personally known to me and is a person I know to be of sound mind.

____________________________________ ____________________________________
Witness Witness

NOTARY PUBLIC
Louisiana Notary # _________________
My commission expires on: __________