New York Living Will

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 and other medical personnel to withhold or withdraw treatment that serves only to prolong the process of 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) if I am 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 strong 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 instructions (insert personal instructions):

I HEREBY APPOINT

_____
(Name)
_____
_____
_____
(Address)
_____
(Phone Number)

as my health care agent to make all health care decisions for me in conformity with the guidelines I have expressed in this document. I direct my agent to make health care decisions in accordance with my wishes and instructions as stated above or as otherwise known to him or her. I also direct my agent to abide by any limitations on his or her authority as stated above or as otherwise known to him or her.

In the event my health care agent is unable, unwilling, or unavailable to serve as such, then I appoint as my substitute health care agent (with the same powers that I have heretofore enumerated).

_____
(Name)
_____
_____
_____
(Address)
_____
(Phone Number)

I understand that unless I revoke it, this living will and health care proxy will remain in effect indefinitely.

These directions express my legal right to refuse treatment, under the laws of New York. Unless I have revoked this instrument or otherwise clearly and explicitly indicated that I have changed my mind, it is my unequivocal intent that my instructions as set forth in this document be faithfully carried out.

_____
(Signature)

_____
_____
_____
(Address)

_____
(Date)

Statement By Witnesses (Must Be 18 or Older)

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.

_____
(Witness)

_____
_____
_____
(Address)

_____
(Witness)

_____
_____
_____
(Address)

KEEP THIS SIGNED ORIGINAL WITH YOUR PERSONAL PAPERS AT HOME. GIVE COPIES OF THE SIGNED ORIGINAL TO YOUR DOCTOR, FAMILY, LAWYER AND OTHERS WHO MIGHT BE INVOLVED IN YOUR CARE.

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