



LIVING WILL (End of Life Care) Instructions

GENERAL INSTRUCTIONS: Use this form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean.

The Living Will is your written directions to your health care power of attorney, also referred to as your “agent”, your family, your physician, and any other person who might make medical care decisions for you if you are unable to communicate yourself.

It is a good idea to talk to your doctor and loved ones if you have questions about the type of care you do or do not want.

IMPORTANT: If you have a Living Will and a Health Care Power of Attorney, you must attach the Living Will to the Health Care Power of Attorney.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:

- (a) under the age of 18
- (b) related to you by blood, adoption, or marriage
- (c) entitled to any part of your estate
- (d) appointed as your agent
- (e) involved in providing your health care at the time this form is signed

**OFFICE OF THE ARIZONA ATTORNEY GENERAL
MARK BRNOVICH**

Living Will

My Information (I am the "Principal"):

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____

Some general statements about your health care choices are listed below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully BEFORE you initial your preferred statement. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3 and 4, BUT if you initial paragraph 5 the others should not be initialed.

_____ 1. If I have a terminal condition I do not want my life to be prolonged, and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

***Comfort care is treatment given in an attempt to protect and enhance the quality of life without artificially prolonging life.*

_____ 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I DO NOT want the following:

_____ a. Cardiopulmonary resuscitation (CPR). For example: the use of drugs, electric shock and artificial breathing.

_____ b. Artificially administered food and fluids.

_____ c. To be taken to a hospital if at all avoidable.

_____ 3. Regardless of any other directions I have given in this Living Will, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ 4. Regardless of any other directions I have given in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____ 5. I want my life to be prolonged to the greatest extent possible (If you initial here, you should not initial any of the others).

PLEASE NOTE: You can attach additional instructions on your medical care wishes that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

_____ A. I HAVE NOT attached additional special instructions about End of Life Care I want.

_____ B. I HAVE attached additional special provisions or limitations about End of Life Care I want.

MY SIGNATURE VERIFICATION FOR THE LIVING WILL

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Living Will expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTORIAL JURAT: Pertains to all three pages of this Living Will

Dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

Principals Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____