**Living Will Template**

 **Date: \_\_\_\_\_\_\_\_\_\_\_\_**

I\_\_\_\_\_\_\_\_\_\_(Declarant name), has residential by the address\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (street)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,(city)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(state),\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Zipcode),with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(contact number)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Email.ID), under full control of my consciousness and awareness with the matter declared the herein statement related to my health-treatment as my consent and announced this as legal document of my desire.

I declared herein\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name),residing at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(streetaddress)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,(city)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(state),\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Zip code), associated with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Institute name),\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(contact number),\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Email.ID), as my health care advocate as well as my agent to take all the decisions in those situations in which I become impair to add a single word. He has all the rights to make decisions in also those situations when I find chronic illness and medical dependent state. My announced agent and health care advocate shall have all the power to deal with all the matters relating to the health maintenance, medical management and wellness program in the case when my physician, primary medical staff proclaim myself not in a condition to make decisions. To make clear fully the time/state of affairs when the agent will be able to use the power of decision making on the behalf of me.

1. Falling into the senseless state
2. Being diagnosed with the chronicle chronic illness
3. Falling in an unreinforced condition

If anyone of the incidents mentioned above happens to me then my willing is not to use any of the medical services mentioned below

* **My desire is to not served by cardiac resuscitation (CPR) as my long-life assistance.**
* **My desire is to not treated in the respiratory or ventilatory state.**
* **I do not prefer the use of the artificial feeding and hydration process to save my life longer**
* **My wish is to not receive and blood transformation**
* **My desire is to not receive any kidney dialysis treatment**

Declarant printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Declarant signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness personal information:**

1st witness printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Id: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation with declarant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_