

LIVING WILL DECLARATION

If I, _____, should lapse into a persistent vegetative state or have an incurable and irreversible condition, that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time AND I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

You may list specific life sustaining treatments you do not want such as cardiac resuscitation, mechanical respiration (i.e. breathing machine) and artificial feeding/fluids by tube. Otherwise, your general statement, above, will stand for your wishes.

I especially **do not want**: _____

You may want to add instructions or care you **do want** – for example, pain medication; or that you prefer to die at home, if possible.

Other instructions/comments _____

Signature Date

Address City State

THIS DOCUMENT MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC

The declarant voluntarily signed this writing in my presence.

Witnessed by: _____
Date _____

Address

City/State

Witnessed by: _____
Date _____

Address

City/State

--- OR---

STATE OF NEBRASKA)
)ss.
COUNTY of _____)

The declarant voluntarily signed this document in my presence on this _____ day of _____, 20____.

Notary Public