



LIVING WILL

(HEALTH CARE INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS)

** This model Living Will form was developed by health care providers to assist you in documenting your health care instructions and preferences. You may use a different Living Will form, if you prefer. Other examples of Living Will forms are available at:*

www.agingwithdignity.org/5wishes.html

www.aging.state.pa.us/aging/lib/aging/AdvanceDirectives.pdf

** In addition to this Living Will form, it is strongly recommended that you also designate a trusted person to be your surrogate decision-maker, in case you become unable to make or communicate treatment decisions for yourself. You can name a surrogate decision-maker by completing a Power of Attorney form, which is available from WellSpan Health.*

The following health care instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my preferences to be followed if I become unable to make or communicate treatment decisions for myself.

IF I HAVE AN END-STAGE MEDICAL CONDITION (WHICH WILL RESULT IN MY DEATH, DESPITE THE INTRODUCTION OR CONTINUATION OF MEDICAL TREATMENT) OR I AM PERMANENTLY UNCONSCIOUS (SUCH AS AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE) AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, I DIRECT MY HEALTH CARE PROVIDERS AND MY SURROGATE DECISION-MAKERS (INCLUDING MY HEALTH CARE AGENTS OR REPRESENTATIVES) TO BE GUIDED BY THE FOLLOWING INSTRUCTIONS:

1. I direct that I be given health care treatment (which could include medications and/or procedures) to relieve my pain or keep me comfortable, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.
2. I direct that any health care treatment that is given primarily for the purpose of prolonging my life (for example, heart-lung resuscitation/CPR, mechanical ventilation, or kidney dialysis) be withheld or withdrawn.
3. I direct that any health care treatment that might otherwise be life-prolonging may be given to me if my health care providers decide that such treatment will relieve my pain or keep me comfortable, or could effectively provide medical benefit to me (for example, radiation therapy for relief of bone cancer, or antibiotics for treatment of fever).
4. I understand that Pennsylvania law presumes that I want nutrition (food) or hydration (water) to be medically supplied to me by a tube into my nose, stomach, intestine, arteries, or veins, unless I specify otherwise. To specify that you do NOT want nutrition (food) or hydration (water) to be medically supplied to you by a tube, please initial the following statement:

_____ I direct that if I have an end-stage medical condition or I am permanently unconscious and there is no realistic hope of significant recovery, I do NOT want nutrition (food) or hydration (water) to be medically supplied to me by a tube.

(continued on other side)

5. **ORGAN DONATION:** To specify that you DO want to be an organ and/or tissue donor, please initial the following statement:

_____ I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donating specific organs or uses for donation of organs and tissues):

Having carefully read this document, I have signed it (or instructed that it be signed on my behalf) on the following date:

Print Name: _____

Signature: _____

Date of Birth: _____

Address: _____

Signature of 1st Witness: _____

Signature of 2nd Witness: _____