LIVING WILL DECLARATION
OF
____

TO MY FAMILY, DOCTORS, AND ALL THOSE CONCERNED WITH MY CARE

Declaration made this _________ day of _______________________, 2020, I, ____________________________ being of sound mind, willfully and voluntarily make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care, and make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any time I have a terminal or incurable or irreversible mental or physical condition and if my attending or treating physician and another consulting physician have determined that there is no medical or reasonable expectation or probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would merely prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain. I do not wish to prolong life on a terminal condition, end–stage condition or persistent vegetative state.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. I expect my family, doctors, and everyone concerned with my care to regard my wishes, and in doing so to be free of any legal liability for having followed my instructions.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

NAME:

PHONE:

I understand the full import of this declaration, and am emotionally and mentally competent.

ADDITIONAL INSTRUCTIONS (Optional) : ____

____

I especially do not want (please initial all that apply) :

___ **Cardiac Resuscitation** ___ **Fluids By Tube** ___ **Hydration/Water**

___ **Mechanical Respiration** ___ **Nutrition/Food** ___ **Artificial Feeding**

____
Witness

____
Signature of Declarant

____
Witness

STATE OF NEW HAMPSHIRE
COUNTY OF HILLSBOROUGH

The foregoing instrument was acknowledged before me this ______ day of ______________, 2020, by______________________, declarant, who is (   ) personally known to me or (   ) who has produced **LICENSE** as identification and who (did/did not) take an oath.

____
NOTARY PUBLIC/JUSTICE OF THE PEACE,
NEW HAMPSHIRE

My Commission Expires:

(SEAL)