

# LIVING WILL (DECLARATION OF END-OF-LIFE WISHES)

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This Living Will (this "**Declaration**") is made on [DATE] by [DECLARANT FULL LEGAL NAME], residing at [DECLARANT ADDRESS], born on [DATE OF BIRTH] (the "**Declarant**," "**I**," or "**me**").

**Recitals.** I am an adult of sound mind and am voluntarily making this Declaration to state my wishes regarding the medical care I want, and do not want, if I become unable to make or communicate my own healthcare decisions and am in a condition described below. I intend this Declaration to guide my family, physicians, and any healthcare agent, and to be honored to the fullest extent permitted by the laws of the State of [STATE]. I make this Declaration after careful reflection and not under duress. In recognition of my right to direct my own medical care, I declare as follows.

## 1. Declaration and Capacity

**1.1 My intent.** This Declaration speaks for me when I cannot speak for myself. It sets out the medical treatment I want and do not want at the end of my life, so that my wishes, rather than the assumptions of others, control my care.

**1.2 Capacity.** I am at least [18] years of age, of sound mind, and acting of my own free will. I understand the nature and consequences of this Declaration, including that following it may shorten or prolong my life.

**1.3 When this Declaration applies.** This Declaration takes effect only if I am unable to make or communicate my own healthcare decisions, as determined and documented by my attending physician and, where required by law, one additional physician, **and** I am in one or more of the qualifying conditions described in Section 2.

**1.4 Voluntariness.** No insurer, healthcare provider, employer, or other person has required me to make this Declaration. It is not a condition of receiving care or coverage.

## 2. Qualifying Medical Conditions

**2.1 Triggering conditions.** This Declaration governs my care if my attending physician determines, to a reasonable degree of medical certainty, that I am in any of the following conditions (initial each that reflects my wishes; leave blank to exclude):

(a) \_\_\_\_ **Terminal condition** — an incurable and irreversible condition that, without life-sustaining treatment, will result in death within a relatively short time.

(b) \_\_\_\_ **Permanent unconsciousness** — a persistent vegetative state or irreversible coma from which, to a reasonable degree of medical certainty, I will not regain consciousness.

(c) \_\_\_\_ **End-stage condition** — an advanced, progressive, and irreversible condition that has resulted in severe and permanent deterioration with no reasonable expectation of recovery.

**2.2 Medical confirmation.** The existence of a qualifying condition must be confirmed in writing in my medical record by my attending physician and any additional physician required by applicable law.

**2.3 Good-faith reliance.** Healthcare providers acting in good-faith reliance on this Declaration and on the certified existence of a qualifying condition are entitled to the protections available under the laws of the State of **[STATE]**.

### 3. Life-Sustaining Treatment Instructions

**3.1 General direction.** If I am in a qualifying condition under Section 2, my general wish is as follows (initial one):

(a) \_\_\_\_ I do **not** want my life prolonged by life-sustaining treatment, and I want such treatment withheld or withdrawn, so that I am allowed to die naturally.

(b) \_\_\_\_ I **do** want life-sustaining treatment provided to the fullest extent medically appropriate, even if there is little or no expectation of recovery.

(c) \_\_\_\_ I want a **trial** of life-sustaining treatment, and if my condition does not improve within **[NUMBER]** days, I want such treatment withdrawn.

**3.2 Defined term.** "Life-sustaining treatment" means any medical procedure, intervention, medication, or device that serves mainly to prolong the dying process and that, in the judgment of my attending physician, would not cure or reverse my qualifying condition. It may include mechanical ventilation, dialysis, cardiopulmonary resuscitation, surgery, and antibiotics used solely to prolong life.

**3.3 Specific treatments.** Beyond my general direction, I give these specific instructions (initial those that apply):

(a) \_\_\_\_ Do not attempt cardiopulmonary resuscitation (CPR). (b) \_\_\_\_ Do not place me on mechanical ventilation, or remove it if started. (c) \_\_\_\_ Do not provide dialysis. (d) \_\_\_\_ Other instructions: **[DESCRIBE]**.

### 4. Artificial Nutrition and Hydration

**4.1 Separate decision.** I understand that artificially administered nutrition and hydration (food and fluids given by tube or intravenously) are treated separately under the law of many jurisdictions, and I address them here specifically.

**4.2 My instruction (initial one).**

(a) \_\_\_\_ I do **not** want artificial nutrition and hydration if I am in a qualifying condition, and I want it withheld or withdrawn.

(b) \_\_\_\_ I **do** want artificial nutrition and hydration provided even if other life-sustaining treatment is withheld or withdrawn.

(c) \_\_\_\_ I want artificial nutrition and hydration provided only if and for so long as it provides comfort or relieves suffering.

### 5. Comfort Care and Pain Relief

**5.1 Comfort always.** Regardless of any instruction above, I want to be kept as clean, comfortable, and free of pain as reasonably possible. I direct that I be given medication, including opioids, and other measures to relieve pain and suffering, even if doing so may unintentionally hasten my death.

**5.2 Palliative and hospice care.** I want palliative or hospice care to be made available to me where appropriate, and I want to be treated with dignity and respect throughout my care.

5.3 **Setting of care.** If feasible and consistent with my medical needs, my preference is to receive end-of-life care at **[HOME / HOSPICE / OTHER]**.

## 6. Pregnancy

6.1 **Effect during pregnancy.** I understand that the laws of some jurisdictions limit the effect of a living will during pregnancy. My wish is (initial one):

(a) \_\_\_\_ This Declaration **remains in full effect** if I am pregnant, to the extent the law allows.

(b) \_\_\_\_ This Declaration is **suspended** during any pregnancy, and I want life-sustaining treatment continued to the extent it may benefit the fetus.

6.2 **Deference to law.** This Section will be applied consistently with the mandatory requirements of applicable law, which may override my stated wish.

## 7. Relationship to Healthcare Agent and Other Documents

7.1 **Healthcare agent.** If I have named a healthcare agent in a separate medical power of attorney or advance directive, I intend that agent to interpret and apply this Declaration and to make decisions consistent with it.  
**[NAME OF AGENT, IF ANY]**.

7.2 **Conflict.** If there is a conflict between this Declaration and another valid healthcare document I have signed, the document that most clearly expresses my wishes on the specific question at issue, or the later-dated document, will control, as permitted by law.

7.3 **Organ donation and autopsy.** My wishes regarding anatomical gifts and autopsy are: **[STATE WISHES, OR "ADDRESSED IN A SEPARATE DOCUMENT," OR "NONE"]**.

## 8. Revocation, Severability, and Effect

8.1 **Revocation.** I may revoke this Declaration at any time and in any manner that communicates my intent to revoke, including by a signed writing, by destroying it, or by orally stating my intent to revoke to my physician or another witness, regardless of my mental or physical condition.

8.2 **Severability.** If any part of this Declaration is found invalid or unenforceable, the remaining parts continue in effect to the fullest extent permitted by law.

8.3 **Copies.** A photocopy, facsimile, or electronic copy of this signed Declaration has the same effect as the original.

8.4 **Binding effect.** I intend this Declaration to be honored by my family, physicians, healthcare providers, and any court, and I direct that my wishes be followed even if others disagree with them.

### SIGNATURE OF DECLARANT

I sign this Declaration knowingly, voluntarily, and after careful thought.

### DECLARANT

Signature: \_\_\_\_\_

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

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Printed name: **[DECLARANT NAME]**

**WITNESSES.** I declare that the Declarant signed this Declaration in my presence, appears to be of sound mind and under no duress, and that I am not the Declarant's attending physician, healthcare agent, or (where required by law) a person entitled to any portion of the Declarant's estate. Witness requirements vary by jurisdiction; confirm the number of witnesses and whether notarization is required under the law of the State of **[STATE]**.

**WITNESS 1**

**WITNESS 2**

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Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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Printed name: **[NAME]**

Printed name: **[NAME]**

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Address: **[ADDRESS]**

Address: **[ADDRESS]**

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

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

**NOTARY ACKNOWLEDGMENT (if required by **[STATE]**).**

State of **[STATE]**, County of **[COUNTY]**. Subscribed, sworn to, and acknowledged before me on **[DATE]** by **[DECLARANT NAME]**.

Notary Public: \_\_\_\_\_ My commission expires: **[DATE]**

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