LIVING WILL DECLARATION

I, _____; being of sound mind, willfully and voluntarily making known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me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.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this decision.

Declarations made this _____ (day) of _____ (month, year)

Signature:

X _____

Address: _____
street **city** **state** **zip**

This document must be witnessed by two individuals *or* acknowledged by a notary public.

Notary Public: Notary Seal:

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me this _____ day of _____ (month, year)

Signature of Notary _____

My appointment expires: _____

or

Witnesses:

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly responsible for declarant's medical care.

Name: _____ Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

This document is based on Kansas Statute 65-28,101 et seq. as amended
Copy protected. Additional forms and information are available through
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