HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONCIOUSNESS (LIVING WILL)

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make, or communication my treatment decisions:

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as in an irreversible coma or irreversible vegetative state and there is no realistic hope of significant recovery, all of the following apply (cross out any treatment instructions with which you do not agree):

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.
2. I direct that all life prolonging procedures be withheld or withdrawn.
3. I specifically do no want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)
   - heart-lung resuscitation (CPR)_____
   - mechanical ventilator (breathing machine)_____
   - dialysis (kidney machine) _____
   - surgery _____
   - chemotherapy radiation treatment _____
   - antibiotics _____

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intenstine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery. (Initial only one statement.)

TUBE FEEDINGS
____ I want tube feedings to be given.

OR

NO TUBE FEEDINGS
____ I do not want tube feedings to be given.

HEALTH CARE AGENT'S USE OF INSTRUCTIONS
(INITIAL ONE OPTION ONLY.)

____ My health care agent must follow these instructions.

OR

____ These instructions are only guidance.

My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions)

If I did not appoint a health care agent, these instructions shall be followed.

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

ORGAN DONATION
(INITIAL ONE OPTION ONLY.)

____ 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 donation of specific organs or tissues or uses for donation of organs and tissues.)

OR

____ I do not consent to donate my organs or tissues at the time of my death.

Having carefully read this document, I have signed it this ____ day of _____, 20___, revoking all previous health care powers of attorney and health care treatment instructions.

SIGNED: _____
(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

WITNESS: _____

WITNESS: _____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, not your creditors, nor employed by any of your health care providers.)

NOTARIZATION (OPTIONAL)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this ____day of _____, 20__, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledge that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of _____ the day and year first above written.

_____

Notary Public

My commission expires _____