

A living will is a document that provides instructions for your care in the event of a terminal condition. This is caused by an incurable injury, disease or illness, and death is imminent without life-prolonging procedures.

The living will directs withholding or withdrawing of procedures that artificially sustain vital functions and prolong the dying process. It requests permission to die naturally with only the provision of appropriate pain easing medication and comfort care. In addition, when making a living will, you have a choice about whether you want to have artificially supplied nutrition and hydration. You can also elect to have your health care representative or your attorney-in-fact with health care powers make these determinations for you.

Competent adults have the right to control the decisions related to their medical care, including life-prolonging procedures. The living will serves as the final expression of your right to refuse treatment and accept the consequences of the refusal.

**Please speak openly with your loved ones about your desire for them to honor your Living Will Declaration.**

## Execution of a Living Will

You may execute a living will if you are 18 years of age or older. The living will must be:

- voluntary
- in writing
- signed by you or another person in your presence and at your expressed direction
- dated
- signed in the presence of a minimum of two competent witnesses who are at least 18 years of age

A living will witness may not be:

- the person who signed the living will on your behalf
- your parent, spouse or child
- entitled to any part of your estate
- financially responsible for your medical care

You should notify your doctor about the living will. He/she will then place a copy of it in your medical record. Legally, the living will does not obligate your doctor to withhold or withdraw life-prolonging procedures. However, the living will is evidence of your desires and will be given great weight in determining your intent if you are unable to give directions regarding your care. A living will is not in effect during a pregnancy.

## Revocation of a Living Will

You may revoke your living will at any time by:

- a signed, dated, written document
- physical cancellation or destruction of a living will by you or another person in your presence and at your direction
- an oral expression of intent to revoke the living will

The revocation is effective when it is communicated to your doctor.

The attached living will form is authorized by the Indiana Code.

There are numerous types of advance directives. Parkview Health encourages you to talk to your doctors, health care team, family and your attorney when completing any advance directive.

**For more information,  
please visit the following websites:**

[www.parkview.com](http://www.parkview.com)  
[www.in.gov/isdh/25880.htm](http://www.in.gov/isdh/25880.htm)

# ADVANCE DIRECTIVE

## Living Will Declaration

*This brochure introduces laws that affect advance directives for health care in Indiana. It provides information about a living will document. It is not intended to substitute for estate planning with an attorney, nor is it a substitute for professional legal advice. Statements reflect legislation in effect in Indiana as of June 1, 2017. Other states have different laws; some information may not apply outside of Indiana.*

## LIVING WILL DECLARATION

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, I, \_\_\_\_\_, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending doctor certifies in writing that: (1) I have an incurable injury, disease or illness; (2) my death will occur within a short period of time; and (3) the use of life-prolonging 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 performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialling or making your mark before signing this declaration):

- I wish to receive artificially supplied nutrition and hydration even if the effort to sustain life is futile or excessively burdensome to me.
- I do not wish to receive artificially supplied nutrition and hydration if the effort to sustain life is futile or excessively burdensome to me.
- I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under I.C. 16-36-1-7, or my attorney in fact with health care powers under I.C. 30-5-5.

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

I understand the full importance of this declaration.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

The declarant has been personally known to me, and I believe (him/her) 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 a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years old.

Signature of Witness #1: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Witness #1 Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Signature of Witness #2: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Witness #2 Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

