

# DOCUMENT RE WITHHOLDING OR WITHDRAWAL OF LIFE SUPPORT SYSTEMS

If the time comes when I am incapacitated to the point when I can no longer participate in decisions for my own life and am unable to direct my physicians as to my own medical care, I wish this statement to stand as a testament of my wishes.

I, \_\_\_\_\_ (name), request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. The life support systems which I do not want include, but are not limited to: Artificial respiration; Cardiopulmonary resuscitation; Artificial means of providing nutrition and hydration. (Cross out and initial desired life support systems you want administered.)

I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

Other specific requests: \_\_\_\_\_

If you wish to appoint a Health Care Agent add the following:

[I appoint \_\_\_\_\_ (name) to be my Health Care Agent. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment, my Health Care Agent is authorized to:

- (1) convey to my physician my wishes concerning the withholding or removal of life support systems
- (2) take whatever actions are necessary to ensure that my wishes are given effect

If this person is unwilling or unable to serve as my Health Care Agent, I appoint \_\_\_\_\_ (name) to be my alternative Health Care Agent.]

This request is made, after careful reflection, while I am of sound mind.

(Signature) \_\_\_\_\_

(Date) \_\_\_\_\_

(Witness) \_\_\_\_\_

(Address) \_\_\_\_\_

(Witness) \_\_\_\_\_

(Address) \_\_\_\_\_

County of \_\_\_\_\_

State of Connecticut

Before me, the undersigned authority, personally appeared \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_ known to me to be declarant and the witnesses whose names are signed to the foregoing instrument, and who, in the presence of each other, did subscribe their names to the Declaration on this date.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public

(Seal)