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LIVING WILL DIRECTIVE

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious, have been indicated by checking and initialing the appropriate lines below. By checking and initialing the appropriate lines, I specifically:

_____ Designate as my health care surrogate(s) to make health care decisions for me in accordance with this directive when I no longer have decisional capacity. If refuses or is not able to act for me, I designate as my health care surrogate(s).

Any prior designation is revoked.

If I do not designate a surrogate, the following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below:

_____ Direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

_____ DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

_____ Authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

_____ DO NOT authorize the withholding or withdrawal of artificially provided food, water or other artificially provided nourishment or fluids.

_____ Authorize my surrogate, designated above, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

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

Signed this _____ day of _____, _____
(year)

Signature and address of the grantor_____

In our joint presence, the grantor, who is of sound mind and eighteen years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor.

Signature and address of witness _____

Signature and address of witness _____

STATE OF KENTUCKY)
_____County)

Before me, the undersigned authority, came the grantor who is of sound mind and eighteen (18) years of age, or older, and acknowledged that he voluntarily dated and signed this writing or directed it to be signed and dated as above.

Done this _____ day of_____, _____
(year)

_____
Signature of Notary Public or other officer.
Date commission expires: _____

Execution of this document restricts the withholding and withdrawing of some medical procedures. Consult Kentucky Revised Statutes or your attorney.

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