Store Data | Retrieve Data | Clear Form | Exit

DECLARATION

If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to give directions regarding my medical treatment, I direct my attending physician, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the moment of my death and is not necessary to my comfort or to alleviate pain.

Signed this _____day of _____, _____
(year)

Signature _____

City, County, and State of Residence _____

The declarant voluntarily signed this document in my presence.

Witness _____

Address _____

Witness _____

Address _____

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am unable to participate in decisions regarding my medical treatment, I appoint or, if he or she is not reasonably available or is unwilling to serve, , to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the moment of my death and is not necessary for my comfort or to alleviate pain, pursuant to the Montana Rights of the Terminally Ill Act.

If the individual I have appointed is not reasonably available or is unwilling to serve, I direct my attending physician, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only serves to prolong artificially the dying process and is not necessary for my comfort or to alleviate pain.

Signed this _____ day of _____, _____
(year)

Signature _____

City, County, and State of Residence _____

The declarant voluntarily signed this document in my presence.

Witness _____

Address _____

Witness _____

Address _____

Name and address of designee.

Name _____

Address _____