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DECLARATION TO PHYSICIANS

1. I, , being of sound mind, voluntarily state my desire that my dying may not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences from this refusal.

2. If I have a TERMINAL CONDITION, as determined by two (2) physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, if I have such a terminal condition, the following are my directions regarding the use of feeding tubes (check only one):

   _____ Use feeding tubes if I have a terminal condition.

   _____ Do not use feeding tubes if I have a terminal condition.

   If I have not checked either line, feeding tubes will be used.

3. If I am in a PERSISTENT VEGETATIVE STATE, as determined by two (2) physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures and feeding tubes:

   a. Check only one:

      _____ Use life-sustaining procedures if I am in a persistent vegetative state.

      _____ Do not use life-sustaining procedures if I am in a persistent vegetative state.

   If I have not checked either line, life-sustaining procedures will be used.

   b. Check only one:

      _____ Use feeding tubes if I am in a persistent vegetative state.

      _____ Do not use feeding tubes if I am in a persistent vegetative state.

   If I have not checked either line, feeding tubes will be used.

4. By law, this document cannot be used to authorize: a) withholding or withdrawal of any medication, procedure or feeding tube if to do so would cause me pain or reduce my comfort, and b) withholding or withdrawal of nutrition or hydration that is administered to me through means other than a feeding tube unless, in my physician's opinion, this administration is medically contraindicated.

5. If I have been diagnosed as pregnant and my physician knows of this diagnosis, this document has no effect during the course of my pregnancy.

Signed_____

Date_____

Address_____

I know the person signing this document personally and I believe him or her to be of sound mind. I am not related to the person signing this document by blood, marriage or adoption, and am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness_____

Witness_____

This document is executed as provided in chapter 154, Wisconsin Statutes.