Living Will Directive
and Health Care Surrogate Designation

Pursuant to KRS 311.625

My wishes regarding life prolonging treatment and artificially provided nutrition and hydration (food, water or other artificially provided nourishment or fluids) to be provided to me if I can no longer make health care decisions and if I either 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:

A. _____ (check and initial, if desired)

Designate _____(name of surrogate) as my health care surrogate(s) to make any health care decisions for me in accordance with this directive when I am no longer able to make health care decisions. If _____(surrogate named above) refuses or is not able to act for me, I designate_____ (name of alternate surrogate) 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 in the event that I develop a terminal condition or permanently unconscious state. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below.

B. _____ (check and initial, if desired)

Direct that life prolonging treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate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

C. _____ (check and initial, if desired)

DO NOT authorize that life-prolonging treatment be withheld or withdrawn.
(Note: Do not check and initial both Section B and Section C.)

D. _____ (check and initial, if desired)

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

E. _____ (check and initial, if desired)

DO NOT authorize the withholding of artificially provided food, water, or other artificially provided nourishment or fluids. (Note: Do not check and initial both Section D and Section E.)

F. _____ (check and initial, if desired)

Authorize my surrogate, designated above, to withhold or withdraw artificially provided food, water, or other 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. (Note: To choose this option, you must have named a surrogate in Section A. Also, if you choose this option, do not check and initial Section B, Section C, Section D, or Section E.)

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

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 _____, 20____.

_____
Signature of Grantor:

Print Name: _____

Address: _____

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 of witness

_____
Print Name

_____
Address

_____
Signature of witness

_____
Print Name

_____
Address

-OR-

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 or she voluntarily dated and signed this writing or directed it to be dated and signed as above.

Done this _____ day of _____, 20____

_____
Signature of Notary Public

_____
Date commission expires

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