LIPCO
LAW FOR ALL

LIVING WILL

Should I no longer be able make any decisions about my future or to consent to medical treatment, let this document stand as an explicit declaration of my wishes in the matter.

Full Name:

ID Number:

Address:

TO MY FAMILY AND MEDICAL PHYSICIAN:

1. Should I be physically ill or impaired causing me to suffer constant pain without a reasonable possibility of recovering or living a normal life again, I wish to be allowed to die in a dignified way, and not be kept alive by machines or other artificial means.

2. During such a time, I ask the medical physician responsible for my medical treatment to administer drugs necessary to keep me free from pain, and as comfortable as possible, even if it will shorten my life.

Initials

Initials

Initials

SIGNATURES

I have signed and dated this document in the presence of the two undersigned witnesses.

Signed at Place on Day of Month 20 Year .

Testator Signature

Witnesses: Signature Witness 1

Signature Witness 2

DISCLAIMER

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