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3 **Disclaimer**
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5 *Please read before preparing any documents of this importance without benefit of an attorney.*
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7 The law office of BRAD S. MARGOLIS has provided the forms for those of you who can
8 not afford an attorney. Be very careful before you attempt to do your own Living will or
9 Health care proxy consult a qualified attorney regarding all your options. While we try
10 to make sure that the information provided is current, complete and accurate, laws can
11 change quickly. You should always formally engage a lawyer of your choosing before
12 taking actions which have legal consequences.
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14 BRAD S. MARGOLIS,ESQ.
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LIVING WILL

TO: My family, physicians and all those concerned with my care

I, _____, presently residing at _____, and being an adult of sound mind, make this declaration as a directive to be followed if for any reason I become unable to make or communicate decisions regarding my medical care.

If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, I direct my attending physician to withhold and withdraw treatment that serves only to prolong my dying. These directions shall apply if (a) I am in a terminal condition, (b) I am permanently unconscious, or (c) I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

The procedures and treatment to be withheld and withdrawn include, without limitation, surgery, antibiotics, cardiac and pulmonary resuscitation, respiratory support, and artificially administered feeding and fluids. I direct that treatment be limited to measures to keep me comfortable and to relieve pain, even if such measures shorten my life.

If, upon my death, any of my tissue or organs would be of value for transplantation, therapy, advancement of medical or dental science, research, or other medical, educational or scientific purpose, I freely give my permission to the donation of such tissue or organs.

These directions are the exercise of my legal right to refuse treatment. Therefore, I expect my family, physicians, health care facilities and all concerned with my care to regard themselves as legally and morally bound to act in accordance with my wishes, and in so doing to be free from any liability for having followed my directions. I intend these directions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

IN WITNESS WHEREOF, I have executed this declaration, as my free and voluntary act and deed, this _____ day of _____, 200__ .

WITNESS:

We, _____ and _____ each hereby attest and declare under penalty of perjury under the laws of New York that: (1) the foregoing instrument was personally signed by _____ in my presence, and thereupon I, at his

1 request and in his presence and in the presence of the other witnesses, have hereunto
2 subscribed my name as a witness; (2) I did not sign the above signature of for or at his
3 direction; (3) I personally know and believe him to be of sound mind and under no
4 constraint, duress, fraud or undue influence; (4) I am not related to by blood, marriage or
5 adoption; (5) I am not entitled (to the best of my knowledge and belief) to any portion of
6 the estate of upon his death under any will or codicil of or by operation of law; (6) I do
7 not have any present or inchoate claim against any portion of the estate of ; (7) I do not
8 have any financial responsibility for the medical care of ; (8) I am not a physician or an
9 employee of any physician, and I am not an operator or employee of, or patient in, any
10 hospital, health care provider, residential care facility, community care facility or similar
11 institution; and (9) I and are both at least 18 years of age.

12
13 Dated: , 200 __

14
15 Witness #1

16 _____

17
18 Residing at

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20 _____

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22 _____

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24
25 Witness # 2

26 _____

27
28 Residing at

29
30 _____
