LIVING WILL

(For Kansas and Missouri residents)

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, subject to later revocation, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, and I am unable to participate in decisions regarding my medical treatment, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally capable to make this declaration.

This declaration is made this _____ day of _____, 20_____.

I do not wish to make additional instructions.

My additional instructions are listed on the reverse side or the attached page(s).

_____

Declarant

This declarant has been personally known to me, and I believe the declarant to be of sound mind and 18 years or older. The declarant voluntarily signed this document in my presence. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, am not entitled to any portion of the estate of the declarant either as a legal heir or under a Will of declarant of any addition thereto, and am not directly financially responsible for declarant's medical care.

_____

Witness

_____

Address

_____

Witness

_____

Address

Discuss this document with your physician(s), family members, friends and clergy and provide them with a signed copy or photocopy.

SEE REVERSE SIDE FOR OPTIONAL ADDITIONAL INSTRUCTIONS

This declaration and additional instructions may be revoked or changed by the declarant at any time.

This document was prepared by the Kansas City metropolitan Bar Association and the Midwest Bioethics Center.

OPTIONAL ADDITIONAL INSTRUCTIONS

If there is a statement below with which you do not agree, draw a line through it and add your initials.

The following (or photocopy thereof) is a statement of my treatment wishes if I lack the capacity to make or communicate decisions regarding m medical treatment and there is no reasonable expectation that I will regain a meaningful quality of life.

- I direct all life sustaining procedures to be withheld or withdrawn if I have:
- a terminal condition, or
- a condition, disease or injury without hope of significant recovery, or
- an extreme medical deterioration, or
- other _____

- Life sustaining procedures I choose to have withheld or withdrawn include:
- surgery
- heart-lung resuscitation (CPR)
- antibiotics
- mechanical ventilator (respirator)
- tube feedings (food, and water delivered through a tube in the vein, nose or stomach)
- other _____

- If my physician believes that a certain life sustaining procedure or other medical treatment may provide me with comfort, relieve pain or lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. If it does not improve my condition, provide comfort or relieve pain, I direct the treatment to be withdrawn even if doing so shortens my life.

- I direct I be given medical treatment to relive pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

- A meaningful quality of life means to me that: (This does not need to be filled in for the instructions to be valid.) _____

_____

- I prefer to live out my last days at home rather than in a hospital or nursing home if it is not a burden to my family.

- If any of my tissues or organs would be of value as transplants to help other people, I freely give my permission for such donation.

- I make other instructions as follows: _____

_____

_____

I have discussed my wishes with the following person(s) and authorize my physician to discuss my treatment and this document with them:

Name	Address	Telephone
Name	Address	Telephone
Name	Address	Telephone

I have read these instructions and have given them careful consideration, and as I have indicated, they are in accordance with my wishes.

Date: _____ Signed: _____
Declarant

_____ _____
Witness Witness