Living Will

I, _____ am of sound mind, and I voluntarily make this declaration.

If I become terminally ill or permanently unconscious as determined by my doctor and at least one other doctor, and if I am unable to participate in decisions regarding my medical care, I intend this declaration to be honored as the expression of my legal right to authorize or refuse medical treatment.

My desires concerning medical treatment are -

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for following my wishes as expressed in this declaration.

I may change my mind at any time by communicating in any manner that this declaration does not reflect my wishes.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

Dated: _____ Signed: _____
(Your signature)

_____

_____
(Address)

STATEMENT OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____
(Print Name) (Signature of Witness)

_____
_____
(Address)

_____ _____
(Print Name) (Signature of Witness)

_____
_____
(Address)

DO-NOT-RESUSCITATE ORDER

I have discussed my health status with my physician, _____. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order is effective until it is revoked by me.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

_____ _____
(Declarant's signature) (Date)

_____
(Type or print declarant's full name)

_____ _____
(Signature of person who signed for declarant, if applicable) (Date)

_____
(Type or print full name)

_____ _____
(Physician's signature) (Date)

_____
(Type or print physician's full name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

_____ _____
(Witness signature) (Date) (Witness signature) (Date)

_____ _____
(Type or print witness's name) (Type or print witness's name)

THIS FORM WAS PREPARED PURSUANT TO, AND IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT

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