

# South Dakota Living Will

## Declaration

This is an important legal document. This document directs the medical treatment you are to receive in the event you are unable to participate in your own medical decision and you are in a terminal condition. This document state what kind of treatment you want or do not want to receive.

Prepare this document carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will remain valid and in effect until and unless you revoke it. Review this document from time to time to make sure it still reflects your wishes. You may change or revoke this document at any time by notifying your doctor and other healthcare providers. You should give copies of this document to your doctor, your family, and your healthcare facility. This form is optional. If you choose to use this form, please note that the form has signature lines for you, two witnesses that you have selected, and a notary public. This form must be signed by two witnesses; notarization is optional.

### To my family, health care provider, and those concerned with my care:

I, \_\_\_\_\_, direct you to follow my wishes for care if I am in a terminal condition, my death is imminent, and I am not able to communicate my decisions regarding my medical care.

With respect to any life-sustaining treatment, I direct the following: *(Initial only one of the following options. If you do not agree with any of the following directives, use the space below to write your own instructions).*

\_\_\_\_\_ If my death is imminent or I am permanently unconscious, I choose not to prolong my life. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

\_\_\_\_\_ Even if my death is imminent or I am permanently unconscious, I choose to prolong my life.

\_\_\_\_\_ I choose neither of the above options, and here are my instructions should I become terminally ill and my death is imminent or I am permanently unconscious.

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**Artificial nutrition and hydration: food and water provided by means of a tube or tubes inserted into the stomach or intestine, or needle into a vein.**

**With respect to artificial nutrition and hydration, I direct the following:** *(initial only one)*

\_\_\_\_\_ If my death is imminent or I am permanently unconscious, I do not want artificial nutrition and hydration. If it has been started, stop it.

\_\_\_\_\_ Even if my death is imminent or I am permanently unconscious; I want artificial nutrition and hydration.

# Living Will

*Declaration* (continued)

Date: \_\_\_\_\_

\_\_\_\_\_  
*(your signature)*

\_\_\_\_\_  
*(your address)*

\_\_\_\_\_  
*(your birth date)*

\_\_\_\_\_  
*(type or print your signature)*

**The declarant voluntarily signed this document in my presence.**

Witness \_\_\_\_\_

Witness \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
On this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, the declarant, \_\_\_\_\_ and  
witnesses \_\_\_\_\_, and \_\_\_\_\_, personally appeared before the  
undersigned officer and signed the foregoing instrument in my presence.

\_\_\_\_\_  
**Notary Public:** \_\_\_\_\_

My commission expires: \_\_\_\_\_

\_\_\_\_\_