COLORADO LIVING WILL
DECLARATION AS TO MEDICAL OR SURGICAL TREATMENT

I, _____, being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

1. If at any time my attending physician and one other physician certify in writing that:

    1. I have an injury, disease or illness which is not curable or reversible and which, in their judgment, is a terminal condition; and

    2. For a period of seven consecutive days or more, I have been unconscious, comatose, or otherwise incompetent so as to be unable to make or communicate responsible decisions concerning my person; then I direct that, in accordance with Colorado law, life-sustaining procedures shall be withdrawn and withheld pursuant to the terms of this declaration; it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain. However, I may specifically direct, in accordance with Colorado law, that artificial nourishment be withdrawn or withheld pursuant to the terms of this declaration.

2. In the event that the only procedure I am being provided is artificial nourishment, I direct that one of the following actions be taken:

    _____ (initials of declarant) a. Artificial nourishment shall not be continued when it is the only procedure being provided; or

    _____ (initials of declarant) b. Artificial nourishment shall be continued for days when it is the only procedure being provided; or

    _____ (initials of declarant c. Artificial nourishment shall be continued when it is the only procedure being provided.

3. I execute this declaration as my free and voluntary act this ___ day of _____, 20_____.
By _____
Declarant

The foregoing instrument was signed and declared by _____ to be his/her declaration, in the presence of us, who, in his/her presence, in the presence of each other, and at his/her request, have signed our names below as witnesses, and we affirm that, at the time of the execution of this instrument, the declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further affirm that neither of us is: (1) a physician; (2) an employee of the declarant's physician; (3) an employee or a patient of a health care facility in which the delcarant is a patient; or (4) a beneficiary, heir, or creditor of the estate of the declarant.

Dated at _____, Colorado, this _____ day of _____, 20 _____.

_____ _____
(Signature of witness) (Signature of witness)

_____ _____
(Address) (Address)

_____ _____

OPTIONAL

STATE OF COLORADO)
) SS.
COUNTY OF _____)

SUBSCRIBED and sworn to or affirmed before me by _____, the declarant, and _____, and _____, witnesses, as the voluntary act and deed of the declarant, this _____ of _____, 20_____.

My commission expires: _____

SEAL _____
Notary Public