PENNSYLVAINIA LIVING WILL
(My specific direction to my family and health care providers)

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of persistent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I do _____I do not _____ want cardio-pulmonary resuscitation.
I do _____I do not _____ want electrocardioversion.
I do _____I do not _____want mechanical respiration.
I do _____I do not _____want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).
I do _____I do not _____want blood or blood products.
I do _____I do not _____want any form of surgery or invasive diagnostic tests.
I do _____I do not _____want kidney dialysis.
I do _____I do not _____want antibiotics.
I do _____I do not _____want to make an anatomical gift of any part of my body, subject to the following limitations, if any: _____

_____

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

I made this declaration on the _____day of _____, 20 __

Declarant's signature: _____
Declarant's address: _____
Declarant's phone: _____

The declarant or the person on behalf of and at the direction of the declarant knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness's signature: _____
Witness's address: _____
Witness's phone: _____

Witness's signature: _____
Witness's address: _____
Witness's phone: _____

PENNSYLVANIA DECLARATION

Durable Power of Attorney for Health Care
(My appointment of a representative)

_____If I should be incompetent or in a state of persistent unconscious, I want to designate another person as my representative to make the types of decisions initialed below. All decisions should be made exactly as I would make them if I were capable. My representative is authorized to:

_____Authorize my admission to a medical, nursing, residential or similar facility and enter into agreement for my care.

_____Authorize medical and surgical procedure.

_____Authorize withholding or withdrawing life-sustaining treatment.

_____Make all other medical treatment decisions.

_____I do not want to designate another person as my representative if I should be incompetent and in a terminal condition or in a state or persistent unconsciousness.

PLEASE NOTE: The Power of Attorney for Health Care has the authority to make organ donation decisions.

Name, address, and phone number of representative, if applicable:

_____
_____
_____

Name, address, and phone number of substitute representative (if representative designated above is unable to serve):

_____
_____
_____

I made this declaration on the _____day of _____, 20 ___

Declarant's signature: _____
Declarant's address: _____
Declarant's phone: _____

The declarant or the person on behalf of and at the direction of the declarant knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness's signature: _____
Witness's address: _____
Witness's phone: _____

Witness's signature: _____
Witness's address: _____
Witness's phone: _____