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 decisions and you are in a terminal condition. This document may state what kind of treatment you want or do not want to receive.

This document can control whether you live or die. 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 periodically to make sure it continues to reflect your wishes. You may amend or revoke this document at any time by notifying your physician and other health-care providers.

You should give copies of this document to your physician and your family. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected and a notary public.

TO MY FAMILY, PHYSICIANS, AND ALL THOSE
CONCERNED WITH MY CARE:

I, _____willfully and voluntarily make this declaration as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my medical care.

With respect to any life-sustaining treatment, I direct the following:
(Initial only one of the following optional directives if you agree. If you do not agree with any of the following directives, space is provided below for you to write your own directives).

___ NO LIFE-SUSTAINING TREATMENT. I direct that no life-sustaining treatment be provided. If life-sustaining treatment is begun, terminate it.

___ TREATMENT FOR RESTORATION. Provide life-sustaining treatment only if and for so long as you believe treatment offers a reasonable possibility of restoring to me the ability to think and act for myself.

___ TREAT UNLESS PERMANENTLY UNCONSCIOUS. If you believe that I am permanently unconscious and are satisfied that this condition is irreversible, then do not provide me with life-sustaining treatment, and if life-sustaining treatment is being provided to me, terminate it. If and so long as you believe that treatment has a reasonable possibility of restoring consciousness to me, then provide life-sustaining treatment.

___ MAXIMUM TREATMENT. Preserve my life as long as possible, but do not provide treatment that is not in accordance with accepted medical standards as then in effect. (Artificial nutrition and hydration is food and water provided by means of a nasogastric tube or tubes inserted into the stomach, intestines, or veins. If you do not wish to receive

this form of treatment, you must initial the statement below which reads: "I intend to include this treatment, among the 'life-sustaining treatment' that may be withheld or withdrawn.")

With respect to artificial nutrition and hydration, I wish to make clear that
(Initial only one)
___ I intend to include this treatment among the "life-sustaining treatment" that may be withheld or withdrawn.
___ I do not intend to include this treatment among the "life-sustaining treatment" that may be withheld or withdrawn.

(If you do not agree with any of the printed directives and want to write your own, or if you want to write directives in addition to the printed provisions, or if you want to express some of your other thoughts, you can do so here).

_____

_____ _____
(Date) (your signature)

_____ _____
(your address) (type or print your signature)
The declarant voluntarily signed this document in my presence.

Witness # 1 _____

Address: _____

Witness 2 _____

Address: _____

The Declarant, _____and witnesses _____

and _____ personally appeared before the undersigned

officer and signed the foregoing instrument in my presence.

Dated this _____ day of _____, _____

_____
Notary Public

My commission expires: _____

SOUTH DAKOTA POWER OF ATTORNEY FOR HEALTH CARE

I appoint_____, whose address is _____

_____, and whose telephone number is _____

as my attorney in fact for health care. I appoint _____

whose address is _____, and whose telephone number is _____, as my successor attorney in fact for health care. I authorize my attorney in fact appointed by this document to make health care decisions. I have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

I direct that my attorney in fact comply with the following instructions or limitations:

_____

_____

I direct that my attorney in fact comply with the following instructions on life-sustaining treatment: (optional) _____

_____

I direct that my attorney in fact comply with the following instructions on artificially administered nutrition and hydration: (optional) _____

_____

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY IN FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

_____

Signature of person making designation/date)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

.

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

OR

State of _____)

) ss.

County of_____)

On this _____day of _____, 2_____, before me, _____

_____, personally came_____

personally to me known to be the person whose name is affixed to the above power of attorney for health care as principal, and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated by this power of attorney for health care.

Witness my hand and notarial seal at _____in such county the day and year last above written.

_____

Seal Signature of Notary Public