TENNESSEE LIVING WILL

I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending physician has determined there is no reasonable medical expectation of recovery and which, as a medical probability, will result in my death, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or the life process, I direct that medical care be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.

ARTIFICIALLY PROVIDED NOURISHMENT AND FLUIDS:
By checking the appropriate line below, I specifically:
_____ Authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.
_____ DO NOT authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.

ORGAN DONOR CERTIFICATION:
Notwithstanding my previous declaration relative to the withholding or withdrawal of life-prolonging procedures, if as indicated below I have expressed my desire to donate my organs and/or tissues for transplantation, or any of them as specifically designated herein, I do direct my attending physician, if I have been determined dead according to Tennessee Code Annotated, § 68-3-501(b), to maintain me on artificial support systems only for the period of time required to maintain the viability of and to remove such organs and/or tissues.

By checking the appropriate line below, I specifically:
_____ Desire to donate my organs and/or tissues for transplantation.
_____ Desire to donate my _____.
(Insert specific organs and/or tissues for transplantation)
_____ **DO NOT** desire to donate my organs or tissues for transplantation.

In the absence of my ability to give directions regarding my medical care, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical care and accept the consequences of such refusal.

The definitions of terms used herein shall be as set forth in the Tennessee Right to Natural Death Act, Tennessee Code Annotated, § 32-11-103.
I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

In acknowledgment whereof, I do hereinafter affix my signature on this the _____day of _____, 20 _____.

_____
Declarant

We, the subscribing witnesses hereto, are personally acquainted with and subscribe our names hereto at the request of the declarant, an adult, whom we believe to be of sound mind, fully aware of the action taken herein and its possible consequence.

We, the undersigned witnesses, further declare that we are not related to the declarant by blood or marriage; that we are not entitled to any portion of the estate of the declarant upon the declarant's decease under any will or codicil thereto presently existing or by operation of law then existing; that we are not the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient; and that we are not persons who, at the present time, have a claim against any portion of the estate of the declarant upon the declarant's death.

_____
Witness

_____
Witness

STATE OF TENNESSEE

COUNTY OF _____

Subscribed, sworn to and acknowledged before me by _____, the declarant, and subscribed and sworn to before me by _____ and _____, witnesses, this _____ day of _____, 20____.

_____
Notary Public

My Commission Expires:

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document you should know these important facts.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes; and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By signing this document, I appoint the person I name below to make health care decisions for me if I am ever unable to make them for myself. I intend for this person to ensure that my living will is honored and that decisions about my medical care respect my wishes as far as they are known. I intend for this person to have the broadest discretion and power allowed by law to approve, refuse or stop medical care for me.

If I should ever reach the point at which my doctor believes I am going to die no matter what is done, I direct this person to ensure that I am allowed to die naturally. That means not starting or continuing to use machines or treatments that would only prolong my dying.

At that point, this person should ensure that I have only the medicine or treatment that I need to keep me comfortable and relieve pain.

In the situation described here,

_____ I authorize this person to approve a treatment or medicine to keep me comfortable and out of pain, even if it may cause permanent physical damage or addiction or hasten my death.
_____ I do not authorize this person to approve a treatment or medicine to keep me comfortable and out of pain, even if it may cause permanent physical damage or addiction or hasten my death.

If I cannot take food and/or liquids by mouth in the situation described here,

_____ I authorize this person to refuse or stop artificial feeding, such as giving me nourishment or fluids through a tube or a vein.
_____ I do not authorize this person to refuse or stop artificial feeding, such as giving me nourishment or fluids through a tube or a vein.

I want this person to have my power of attorney to do the things I described above:
Person to have Power of Attorney for Health Care (Attorney in Fact):

Name: _____
Street Address: _____
City: _____ State: _____
Telephone: _____

If the person named above is unable to unwilling to serve, I appoint the following person as my successor (backup) attorney in fact with full powers and responsibilities to make health care decisions on my behalf.

Backup Person to have Power of Attorney for Health Care (Successor Attorney in Fact)

Name: _____

Street Address: _____

City: _____ State: _____

Telephone: _____

I authorize the use of copies of this document.

I hereby execute this Durable Power of Attorney for Health Care on the _____day of _____, 20 _____.

_____

My signature

Person giving the Power of Attorney for Health Care (Principal)

Declaration of Witnesses

Each of the undersigned witnesses makes the following declaration: "I declare under penalty of perjury under the laws of Tennessee that the person who signed this document is personally known to me to be the principal; that the principal signed this durable power of attorney in my presence; that the principal appears to be of sound mind and under no duress, fraud or undue influence; that I am not the person appointed as attorney in fact by this document; that I am not a health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution; that I am not related to the principal by blood, marriage, or adoption; that, to the best of my knowledge, I do not, at the present time, have a claim against any portion of the estate of the principal upon the death of the principal; and, that to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will or codicil thereto now existing, or by operation of law."

_____ _____

Signature of Witness Signature of Witness

Date: _____ Date: _____

STATE OF TENNESSEE

COUNTY OF _____

Subscribed, sworn to and acknowledged before me by _____ the principal, and subscribed and sworn to before me by _____ and _____, witnesses, this _____ day of _____, 20___

_____ My commission expires: _____

Notary Public