# SOUTH DAKOTA LIVING WILL DECLARATION

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

Prepare this living will 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 living will remains valid and in effect until and unless you revoke it. Review this living will periodically to make sure it continues to reflect your wishes. You may amend or revoke this living will at any time by notifying your physician and other health care providers. You should give copies of this living will to your family , your physician, and your health care facility. 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, HEALTH CARE PROVIDER, AND ALL 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 unable to communicate my decisions about 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 either of the following options, space is provided below for you 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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_____

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Artificial Nutrition and Hydration: food and water provided by means of a tube 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.

Date: _____

_____

(Your signature)

_____

(Type or print your signature)

_____

(Your address)

The declarant voluntarily signed this document in my presence.

Witness _____

(Signature)

_____

(Type or print signature)

Address _____

(Street) (City) (State)

Witness _____

(Signature)

_____

(Type or print signature)

Address _____

(Street) (City) (State)

On this the _____ day of _____, _____, 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: _____

{Seal}

Source: SDCL 34-12D-3