

INDIANA LIVING WILL DECLARATION (07/2023)

I.C. 16-36-4

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

LIVING WILL DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that:

- (1) I have an incurable injury, disease, or illness;
- (2) my death will occur within a short time; and
- (3) the use of life prolonging procedures would serve only to artificially prolong the dying process,

I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. *(Indicate your choice by initialing or making your mark before signing this declaration.):*

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers appointed under IC 30-5-5-16.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed _____

City, County, and State of Residence

WITNESSES OR NOTARY

The declarant has been personally known to me and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Date (month, day, year) _____

Witness _____ Date (month, day, year) _____

State of Indiana)

County of _____) SS:

Before, me, a Notary Public in and for said county and State, personally appeared _____, known to me to be the person identified as the declarant in the foregoing Living Will, and who, being by me duly sworn, acknowledged that they executed the foregoing Living Will as their voluntary act for the purposes stated therein.

Witness my hand and Notarial Seal this _____ day of _____, 20_____.

Notary Public _____

Notary's name printed: _____

Commission Number _____

My Commission Expires: _____

Resident of _____ County