

WASHINGTON D.C. LIVING WILL DECLARATION

This Declaration made this ____ day of _____, 20____.

I, _____, being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by 2 physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process:

(Choose One and Initial)

_____ - I direct that such procedures **NOT to be withheld or withdrawn**, and that I be granted access to every measure possible to extend my life.

_____ - I direct that such procedures **to be withheld or withdrawn**, and that I be permitted to die naturally with only the administration of medication, or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

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

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Declarant's Signature: _____ **Date:** _____

Address: _____

I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least 18 years of age and am not related to the declarant by blood, marriage, or domestic partnership, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

Witness's Signature: _____ **Date:** _____

Witness's Signature: _____ **Date:** _____

