

B. _____ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

The following line is not part of the standard South Carolina form. It has been added at the request of many people as a point of clarification. If you do want it to apply, please initial the line below:

C. _____ Nevertheless, I do want treatment to ensure my comfort and to relieve pain and suffering and minimal intravenous fluids to avoid discomfort.

3. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

4. I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.

APPOINTMENT OF AN AGENT (OPTIONAL)

1. You may give another person authority to revoke this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

Name of Agent with Power to Revoke: _____

Address: _____

Telephone Number: _____

2. You may give another person authority to enforce this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

Name of Agent with Power to Enforce: _____

Address: _____

Telephone Number: _____

REVOCAION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN.

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF YOUR INTENT TO REVOKE, BY YOU OR BY SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE ORIGINAL DECLARATIONS REVOKES ALL OF THE ORIGINAL DECLARATIONS;

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE;

any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the Declarant; nor the Declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the Declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the Declarant is a patient. If the Declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

Witness

Witness

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

Notary Public for South Carolina
My Commission Expires: _____ (SEAL)