LIVING WILL or HEALTH CARE INSTRUCTIONS

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	Provide	Withhold
Cardiopulmonary Resuscitation		
Artificial Respiration (including a respirator)		
Artificial means of providing nutrition and hydration		
_____		
_____		

Other specific requests: _____

_____

_____

_____

_____

_____

_____

_____

_____

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

This request is made, after careful reflection, while I am of sound mind.

_____ / _____ / _____ (Date) X_____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this living will or health care instructions by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of_____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I understand that, as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and will turn to someone who knows my values and health care wishes. By signing this appointment of health care representative, I appoint a health care representative with legal authority to make health care decisions on my behalf in such case or at such time.

I appoint _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment **my health care representative is authorized make any and all health care decisions for me, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and the decision to provide, withhold or withdraw life support systems**, except as otherwise provided by law which excludes for example psychosurgery or shock therapy.

I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in a living will, or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

This request is made, after careful reflection, while I am of sound mind.

_____ / _____ / _____ (Date) X_____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this appointment of a health care representative by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)