NEW YORK LIVING WILL

This Living Will has been prepared to conform to the law in the State of New York, as set forth in the case In re Westchester County Medical Center, 72 NY2d 517 (1988). In that case the Court established the need for "clear and convincing" evidence of a patient's wishes and stated that the "ideal situation is one in which the patient's wishes were expressed in some form of writing, perhaps a 'living will."

[PRINT YOUR NAME]

I, _____, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in an **incurable or irreversible mental or physical condition with no reasonable expectation of recovery.**

These instructions apply if I am (a) **in a terminal condition;** (b) **permanently unconscious;** or (c) **if I am minimally conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.**

I direct that my treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

[CROSS OUT ANY STATEMENTS WITH WHICH YOU DO NOT AGREE]

While I understand that I am not legally required to be specific about future treatments **if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:**

I do not want cardiac resuscitation.

I do not want mechanical respiration.

I do not want artificial nutrition and hydration.

I do not want antibiotics.

However, I **do want** maximum pain relief, even if it may hasten my death.

[ADD PERSONAL INSTRUCTIONS (IF ANY)]

Other directions:

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

[SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS]

Signed: _____ Date: _____

Address: _____

_____

[YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES]

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness #1:

Signed: _____

Address: _____

Witness #2:

Signed: _____

Address: _____

NEW YORK HEALTH CARE PROXY
[PRINT YOUR NAME]

(1) I, _____, (name) hereby appoint: _____
_____
_____

(PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR HEALTH CARE PROXY) as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

This Health Care Proxy shall take effect in the event I become unable to make my own health care decisions. **(ADD PERSONAL INSTRUCTIONS, IF ANY)**

(2) Optional instructions: I direct my proxy to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. *(Unless your agent knows your wishes about artificial nutrition and hydration ceding tubes], your agent will not be allowed to make decisions about artificial nutrition and hydration.)*_____
_____
_____

(3) Name of substitute or fill-in proxy if the person I appoint above is unable, unwilling or unavailable to act as my health care agent._____
_____
_____

(PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE PROXY)

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired): _____
(ENTER A DURATION OF A CONDITION, IF ANY)

(SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS)

(5) Signature:_____ Date: _____

Address: _____

_____

STATEMENT BY WITNESSES (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as proxy by this document.

(YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES)

Witness #1:

Signed: _____

Print Name: _____

Address: _____

Witness #2:

Signed: _____

Print Name: _____

Address: _____

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.