DECLARATION

_____ This declaration is made by _____ I being of sound mind, willfully
initial and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstance set forth below do hereby declare:

_____ This declaration is made by _____ The responsible party for _____
initial who is mentally/physically unable to make appropriate medical decisions due to _____.

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the other a consulting physician. If 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 prolong artificially the dying process. I direct that such procedures be withheld or withdrawn. And that I'm allowed to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care as is directed below.

_____ Do use antibiotics.	_____ Do not use antibiotics.
_____ Do use IV therapy.	_____ Do not use IV therapy
_____ Do transfer to a hospital	_____ Do not transfer to a hospital
_____ Do admit to ICU	_____ Do not admit to ICU
_____ Do use a feeding tube	_____ Do not use a feeding tube
_____ Do use dialysis	_____ Do not use dialysis
_____ Do use respirator	_____ Do not use respirator
_____ Do use CPR	_____ Do not use CPR

In the absence of my ability to give directions regarding the use of such life –sustaining procedures, it is my intentions that this declaration shall be honored by my family and physicians. As the final expression of my legal right to refuse medical and surgical treatment and accept the consequences for such refusal.

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

Due to the resident's health or mental capability the following family members or responsible party are making medical decisions regarding the resident's health care. It is understood and agreed that I/we for heirs, successors, estates, executors, and administrators, agree to hold the attending physician, and Premier Hospice employees, agents, staff, and directors free from any and all liability and responsibility arising from any action taken in connection with the attached request.

_____	_____
Patient Signature/Responsible Party	Date
_____	_____
Witness	Relationship
_____	_____
Witness	Relationship
_____	_____
Attending Physician	Date
_____	_____
Medical Director	Date