COMMON LAW LIVING WILL

The following is a statement of my treatment wishes if I lack the capacity to make or communicate decisions regarding my health care treatment. I place much importance on my ability to live a meaningful life, to interact with others, to care for myself, and to engage in intellectual activity. I do not desire to live life in any condition in which I have little or no chance of regaining sufficient mental faculties to interact with others in a meaningful manner.

IF THERE IS A PHRASE, STATEMENT, OR SECTION BELOW WITH WHICH YOU DO NOT AGREE, DRAW A LINE THROUGH IT AND ADD YOUR INITIALS.

Therefore, I direct that life-prolonging procedures be withheld or withdrawn when there is no hope of significant recovery and I have:

- **a terminal condition, or**
- **a condition, disease, or injury without reasonable expectation that I will regain an acceptable quality of life, or**
- **substantial brain damage or brain disease that cannot be significantly reversed.**

When any of the above conditions exist, I choose to have the following life-prolonging procedures withheld or withdrawn:

- **surgery**
- **dialysis**
- **heart-lung resuscitation ("CPR")**
- **antibiotics**
- **mechanical ventilator (respirator)**
- **tube feeding (food and water delivered through a tube in the veins, nose, or stomach)**
- **other**_____

If my physician believes that a certain life-prolonging procedure or other health care treatment may provide me with comfort, relieve pain, or lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. However, if it does not significantly improve my condition, provide comfort, or relieve pain, I direct that the procedure or treatment be withdrawn, even if doing so shortens my life.

I direct I be given health care treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

I have read these instructions and have given them careful consideration, and they are in accordance with my wishes.

Dated: _____, 20____

_____

Signature

This document must be dated and signed in the presence of two witnesses or acknowledged by a notary public.

WITNESSES

The witnesses must not be (i) the health care agent; (ii) related to the principal by blood, marriage, or adoption; (iii) entitled to any portion of the declarant's estate; or (iv) not financially responsible for principal's health care.

Witness _____ Witness _____

Address _____ Address _____

OR

NOTARY PUBLIC

STATE OF KANSAS, COUNTY OF _____, ss:

The foregoing instrument was acknowledged before me this ____ day of _____, 20____, by _____.

_____
Notary Public