

LOUISIANA DECLARATION OF LIVING WILL

Declaration made this _____ day of _____, 200_____.

_____, being of sound mind, willfully and voluntarily make known
(*Enter Your Name Here*)
my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease, or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be in a terminal and irreversible condition by two physicians who have personally examined me, one of whom shall be my attending physician, and 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 (*Place your Initials on one line only*):

_____ that all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively,

_____ that life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

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

SIGNED: _____

PRINTED NAME: _____

CITY, PARISH AND STATE OF RESIDENCE:

_____, Parish of _____, State of Louisiana.

The Declarant has been personally known to me, I believe him/her to be of sound mind.

WITNESSES: _____

PRINTED NAME: _____

PRINTED NAME: _____

This Declaration should be filed in your medical record at each of your physicians' offices to ensure your wishes are followed and a copy should also be provided to your attorney and/or family member(s).