ST. MARY'S MEDICAL CENTER
3700 WASHINGTON AVENUE
EVANSVILLE, INDIANA 47750
(812) 485-4000

ST. MARY'S

Living Will

A Living Will is a voluntarily executed document put into writing. It is signed by the person making the declaration. If that person is unable to sign the document, he or she may ask another individual to sign it, but it must be done in the presence of the person whose name appears on the declaration. It must be dated and signed in the presence of at least two witnesses. A witness may not be the individual signing on behalf of the person; a parent, spouse, or child of the person; entitled to any part of the person's estate; or directly and/or financially responsible for the person's medical care.

A Living Will facilitates the person's desire to either withhold or withdraw life-prolonging procedures that would artificially prolong the dying process. Appropriate nutrition and hydration, medication to ease pain, and comfort care will be provided.

A Living Will may be revoked at any time by a signed and dated revocation, physical cancellation such as destroying the Living Will, or by telling others that it is being revoked. If the Living Will is revoked, the physician must be told.

A Living Will does not become effective until the patient meets three conditions. They are:

1. The patient has been diagnosed as having an incurable injury, disease, or illness
2. A physician has certified in writing that the patient is in terminal condition - meaning that there can be no recovery and death will occur within a short period of time
3. And that life-prolonging procedures would only prolong the dying process

In the instance that the patient is pregnant, a Living Will is not valid.

NOT PART OF PERMANENT MEDICAL RECORD

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Steps in completing a Living Will:

1. Obtain the form appropriate for Indiana. A sample form is attached to these instructions. A copy may also be obtained by contacting a personal attorney, the Indiana Bar Association, The Society for the Right to Die/Concern for Dying, or the American Association of Retired Persons.

2. The basic form may be modified or expanded to meet the specific needs or healthcare desires of the individual. Those persons wishing to modify the form are encouraged to speak to an attorney.

3. A person desiring to sign a Living Will is highly encouraged to sign and date it and have it properly witnessed BEFORE entering the hospital. Any friend, neighbor, non-relation can be a witness. A witness should have no custodial responsibility over the person signing the Living Will.

4. Each hospital is encouraged to carefully consider whether its staff may act as a witness. Although it is not illegal to do so, healthcare workers providing care to the patient should NOT act as witnesses because of possible conflict of interest. Non-clinical staff such as those from a Pastoral Care Department and Social Services may be appropriate witnesses.

5. A copy of the Living Will should be placed in the patient's medical record upon admission and the patient should distribute copies to his/her physician, attorney, and close family members.

6. A copy of the Living Will should be presented each time one is admitted to a hospital so that it may be entered into the medical chart for that particular admission.

7. Hospital personnel are encouraged NOT to answer any questions with legal implications. For such questions, the patient is encouraged to contact his/her personal attorney. The hospital department of Risk Management is also available for consultation.

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INDIANA - LIVING WILL DECLARATION

DECLARATION made this _____ day of _____
(date) (month, year)

I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury or disease, or illness; (2) my death will occur within a short time; and (3) the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my healthcare representative appointed under IC 16-36-1-7 or my attorney in fact with healthcare powers under IC 30-5-5

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

Other directions (optional):

I understand the full import of this declaration.

_____ _____ _____
(Signature) (Date/Time) (Printed)

_____
(City, County & State of Residence)

The declarant has been personally known to me. I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness: _____ **Date/Time:** _____

Address: _____

Witness: _____ **Date/Time:** _____

Address: _____

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