INDIANA LIVING WILL

Declaration made this _____ day of ___________ (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, 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procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort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 health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care 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 that 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.

I understand the full import of this declaration.

Signed ____

____
City, County, and State of Residence

The declarant has been personally known to me, and 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 ____

Witness ____
Date ____

INDIANA LIFE PROLONGING PROCEDURES DECLARATION

Declaration made this ______ day of __________________________ month, year.
I, ____
being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

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

I understand the full import of this declaration.

Signed ______________________________________

____

City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____________________________________

Date ____

Witness _____________________________________

Date ____

Indiana Power of Attorney for Healthcare Decisions and Appointment of Healthcare Representative

1) I, ____
(name)
of ____,________
(address)
hereby appoint ____
(name of attorney-in-fact)
____
(address)
____
(home telephone number) *(work telephone number)* *(cell telephone number)*

as my attorney-in-fact to make healthcare decisions on my behalf whenever I am incapable of making my own healthcare decisions.

I grant my attorney-in-fact the following powers in matters affecting my healthcare:
(1) to employ or contract with servants, companions, or healthcare providers involved in my health care;
(2) to admit or release me from a hospital or healthcare facility;
(3) to have access to my records, including medical records;
(4) to make anatomical gifts on my behalf;
(5) to request an autopsy; and
(6) to make plans for the disposition of my body.

2) In the event the person I appoint above is unable, unwilling or unavailable to act as my attorney-in-fact, I hereby appoint:

____
(name of successor attorney-in-fact)
of ____
(address)
____
(home telephone number) *(work telephone number)* *(cell telephone number)*

as my successor attorney-in-fact.

Appointment of my Attorney-in-Fact as my Healthcare Representative

In addition to the powers granted above, I appoint my attorney-in-fact as my **healthcare representative** to make decisions in my best interest concerning the consent, withdrawal or withholding of healthcare. I understand healthcare to include any medical care, treatment, service, or procedure to maintain,

diagnose, treat, or provide for my physical or mental well-being. Healthcare also includes the providing of nutrition and hydration through intravenous, gastrostomy or nasogastric tubes.
If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my healthcare representative is satisfied that certain healthcare is not or would not be beneficial, or that such healthcare is or would be excessively burdensome, then my healthcare representative may express my will that such healthcare be withheld or withdrawn and may consent on my behalf that any or all healthcare be discontinued or not instituted, even if death may result.

My healthcare representative must try to discuss this decision with me. However, if I am unable to communicate, my healthcare representative may make such a decision for me, after consultation with my physician or physicians and other relevant healthcare givers. To the extent appropriate, my healthcare representative may also discuss this decision with my family and others, to the extent they are available.

I, ________________________________, the principal, sign my name to this instrument this ______ day of _____________ 20____,

and do hereby declare to the undersigned witness that I sign it willingly, and I execute it as my free and voluntary act for the purposes here in expressed, and that I am eighteen years of age or older, of sound mind, and under no constraint or undue influence.

____
(principal)

Subscribed and acknowledged before me by _______________________________________, the principal, this _____ day of _______________________________, 20______.

____
(notary public)

My Commission expires _________________

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.