KANSAS LIVING WILL

Declaration made this _____day of_____(month, year) I, _____ _____being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare: 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 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procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me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_____

_____
City, County and State of Residence

The declarant has been personally known to me and I believe him or 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 related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness _____ Witness _____

STATE OF_____)

COUNTY OF_____)

This instrument was acknowledged before me on _____(date)
_____ (name of person)

_____ (signature of notary public)(Seal, if any)

My appointment expires: _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GENERAL STATEMENT OF AUTHORITY GRANTED

I, _____designate and appoint:

Name _____ Address _____

Telephone Number_____to be my agent for health care decisions and pursuant to the language stated below, on behalf to: (1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body; (2) Make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care as the agent shall deem necessary for my physical, mental and emotional well-being; and (3) Request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my agent for health care shall: _____
_____

(Here may be inserted any special instructions or statement of the principal's desired to be followed by the agent in exercising the authority granted.)

LIMITATIONS OF AUTHORITY

(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

(2) The agent shall be prohibited from authorizing consent for the following items:

_____

(3) This durable power of attorney for health care decisions shall be subject to the additional following limitations:

_____

EFFECTIVE TIME

This power of attorney for health care decisions shall become effective when i am unable to lmake decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

EXECUTION

Executed this _____, at _____, Kansas

_____(Principal)

This document must be: (1) witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage or adoption, not entitled to any portion of principal's estate and not financially responsible for principal's health care: OR (2) acknowledged by a notary public.

Witness 1 Signature_____ Date _____

Witness 1 Name (Print) _____

Address _____

Witness 2 Signature_____ Date _____

Witness2 Name (Print) _____

Address _____

(or)

STATE OF _____)

COUNTY OF _____)

This instrument was acknowledged before me on _____(date)

by _____ (name of person)

_____ (signature of notary public)

(Seal, if any)

My appointment 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.