MASSACHUSETTS LIVING WILL

TO: My family, physicians and all
those concerned with my care

I, ____

presently residing at_______________________________,________, and being an adult of sound mind, make this declaration as a directive to be followed if for any reason I become unable to make or communicate decisions regarding my medical care.

I do not want medical treatment that will keep me alive if I am unconscious and there is no reasonable prospect that I will ever be conscious again (even if I am not going to die soon in my medical condition) or if I am near death from an illness or injury with no reasonable prospect of recovery. The procedures and treatment to be withheld and withdrawn include, without limitation, surgery, antibiotics, cardiac and pulmonary resuscitation, respiratory support, and artificially administered feeding and fluids. I direct that treatment be limited to measures to keep me comfortable and to relieve pain, even if such measures shorten my life.

[OPTIONAL] ____________ (Initial) I wish to live out my last days at home rather than in a hospital, if it does not jeopardize the chance of my recovery to a meaningful and conscious life and does not impose an undue burden on my family.

[OPTIONAL] ____________ (Initial) If, upon my death, any of my tissue or organs would be of value for transplantation, therapy, advancement of medical or dental science, research, or other medical, educational or scientific purpose, I freely give my permission to the donation of such tissue or organs.

These directions are the exercise of my legal right to refuse treatment. Therefore, I expect my family, physicians, health care facilities and all concerned with my care to regard themselves as legally and morally bound to act in accordance with my wishes, and in so doing to be free from any liability for having followed my directions.

IN WITNESS WHEREOF, I have executed this declaration, as my free

and voluntary act and deed, this ____day of _________, 20______.

____
Signature of Principal

WITNESS:

We, the undersigned witnesses, each hereby attest and declare under penalty of perjury under the laws of the Commonwealth of Massachusetts that: (1) the foregoing instrument was personally signed by ___________________________________ in my presence, and thereupon I, at his request and in his/her presence and in the presence of the other witnesses, have hereunto subscribed my name as a witness; (2) I did not sign the above signature of _______________________________for or at his/her direction; (3)

I personally know ____and believe him/her to be of sound mind and under no constraint, duress, fraud or undue influence; (4) I am not related to ___________________________________ by blood, marriage or adoption; (5) I am not entitled (to the best of my knowledge and belief) to any portion of the estate of _____________________________________ upon his/her death under any will or codicil of ____ or by operation of law; (6) I do not have any present or inchoate claim against any portion of the estate of __________ ______________________________; (7) I do not have any financial responsibility for the medical care of ____; (8) I am not a physician or an employee of any physician, and I am not an operator or employee of, or patient in, any hospital, health care provider, residential care facility, community care facility or similar institution; and (9) I am at least 18 years of age.

Dated: _____________________, 20______

____
Signature of Witness 1

residing at

____
____

____
Signature of Witness 2

residing at

____
____

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.

MASSACHUSETTS HEALTH CARE PROXY

I, ____(the Principal),

born on ___________ and residing at ____________________________, Massachusetts, pursuant to Massachusetts General Laws Chapter 201D, appoint the following person to be my Health Care Agent:

Name:_________________________________ Phone #:____________________________

Address:_______________________ City/State/Zip:__________________________________

If my Health Care Agent named above is not available or declines to serve, I name as an alternate Health Care Agent:
Name:_________________________________ Phone #:____________________________

Address:_______________________ City/State/Zip:__________________________________

I give my Health Care Agent authority to make all health care decisions on my behalf if I become incapable of making such decisions for myself, including but not limited to decisions concerning initiation, continuing, withdrawing or refusing any life-prolonging care, treatment, service or procedure, EXCEPT (here list the limitations, IF ANY, you wish to place on your Agent's authority):____
____
____

My Health Care Agent shall make health care decisions for me in accordance with my Health Care Agent's assessment of my wishes, including my religious and moral beliefs. If my wishes are unknown, my Health Care Agent shall make such decisions for me only in accordance with my Health Care Agent's assessment of my best interests.

My Agent may obtain any and all medical information, including medical information, as I would be entitled to receive. My Health Care Agent's authority to act on my behalf shall exist only for the period during which my attending physician determines that I lack capacity to make or communicate health care decisions for myself.

I sign this Health Care Proxy on _______________, 20_____ in the presence of two witnesses.

Signed: ____

(If the Principal cannot sign) The principal is unable to sign and at the direction of the principal I have signed his/her name in his/her presence and in the presence of two witnesses.
Name: ____
Street: ____________________________City/Town:_____________________________

We, the undersigned witnesses, each declare in the presence of the principal that neither of us has been named as Health Care Agent or alternate Health Care Agent in this Health Care Proxy, and we further declare that the principal signed this instrument as his/her Health Care Proxy, or directed its execution, in the presence of each of us, that each of us signs this Health Care Proxy as witness in the presence of the principal, and that to the best of our knowledge he/she is eighteen (18) years of age or over, of sound mind, and under no constraint or undue influence.

Witness: ________________________________ Printed Name: _________________________

Address: ____

Witness: ________________________________ Printed Name: _________________________

Address: ____

STATEMENT OF HEALTH CARE AGENT (OPTIONAL)

Health Care Agent: I have been named by ______________________________________ (the "principal") as the principal's **Health Care Agent** by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes at a time of possible incapacity, and I will try to give effect to the principal's wishes. I am not an operator, administrator or employee of a hospital, nursing home, rest home, Soldiers Home or other health facility where the principal is presently a patient or resident or has applied for admission; or if I am such a person, I am also related to the principal by blood, marriage or adoption.

Signature of **Health Care Agent:** _______________________________ Date: ________

STATEMENT OF ALTERNATE HEALTH CARE AGENT (OPTIONAL)

Alternate: I have been named by ____ the "principal") as the principal's **Alternate Health Care Agent** by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes. I am not an operator, administrator or employee of a hospital, nursing home, rest home, Soldiers Home or other health facility where the principal is presently a patient or resident or has applied for admission; or if I am such a person, I am also related to the principal by blood, marriage or adoption.

Signature of **Alternate Health Care Agent:** ______________________ Date: ____________

This Health Care Proxy Form is adapted from a form prepared by The Central Massachusetts Partnership to Improve Care at the End of Life. The Partnership grants to reproduce this document in its entirety, so long as the source, including this statement, is shown. 12/03 BIDMC revision, 3/10. MC0874

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