MONTANA DECLARATION OF LIVING WILL APOINTMENT

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I appoint _____ _____, whose address is _____ _____, and whose telephone number is _____, or, if he or she is not reasonably available or is unwilling to serve, I appoint_____whose address is _____, and whose telephone number is _____, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to the Montana Rights of the Terminally Ill Act. If the individual(s) I have appointed is not reasonably available or is unwilling to serve, I direct my attending physician, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

Signed this _____ day of _____, 20_____.

_____ _____
Signature of Declarant Printed Name of Declarant

_____
Address, City, County and State of residence of Declarant

The declarant is known to me, is eighteen years of age or older, of sound mind and voluntarily signed this document in my presence.

_____ _____
Signature of Witness # 1 Printed Name of Witness # 1

_____
City, County and State of residence of Witness # 1

_____ _____
Signature of Witness # 2 Printed Name of Witness # 2

_____
City, County and State of residence of Witness # 2

MONTANA DECLARATION OF LIVING WILL

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician or my attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally III Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Signed this _____ day of _____, 20_____.

_____ _____

Signature of Declarant Printed Name of Declarant

_____

Address, City, County and State of residence of Declarant

The declarant is known to me, is eighteen years of age or older, of sound mind and voluntarily signed this document in my presence.

_____ _____

Signature of Witness # 1 Printed Name of Witness # 1

_____

City, County and State of residence of Witness # 1

_____ _____

Signature of Witness # 2 Printed Name of Witness # 2

_____

City, County and State of residence of Witness # 2