



## MONTANA DECLARATION OF LIVING WILL APOINTMENT

If I should have an incurable and irrev		
treatment, will, in the opinion of my		
and I am no longer able to make decision	ions regarding my medical treatment,	1 appoint
, whose address, and whose telephone i	number is	or if he or she is not
reasonably available or is unwilling to	serve I appoint	whose address
is	serve, rappoint	and whose telephone
reasonably available or is unwilling to isnumber is	, to make decisions on my bel	nalf regarding withholding or
withdrawal of treatment that only pro- to alleviate pain, pursuant to the Mon appointed is not reasonably available to the Montana Rights of the Termina the process of dying and is not necessar	longs the process of dying and is not name and Rights of the Terminally III Actor is unwilling to serve, I direct my ally III Act, to withhold or withdraw	necessary for my comfort or ct. If the individual(s) I have attending physician, pursuant treatment that only prolongs
Signed this day of		
Signature of Declarant	Printed Name of Declarant	
Address, City, County and State of res	sidence of Declarant	
The declarant is known to me, is eight this document in my presence.	een years of age or older, of sound m	ind and voluntarily signed
Signature of Witness # 1	Printed Name of Witness # 1	
City, County and State of residence of	Witness # 1	
	D. L. LAY CYYY	
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 Declar	arant	Printed Name of Declarant	-
Address, City, Co	unty and State of re	esidence of Declarant	-
The declarant is k this document in i	_	nteen years of age or older, of sound mind and	l voluntarily signed
Signature of Witn	ess # 1	Printed Name of Witness # 1	-
City, County and	State of residence of	of Witness # 1	-
Signature of Witn	ess # 2	Printed Name of Witness # 2	-
City, County and	State of residence of	of Witness # 2	-