

Living will made this \_\_\_\_\_ day of \_\_\_\_\_ (month/year).

I, \_\_\_\_\_, being of sound mind, willfully and voluntarily make known my desire that my life shall not be prolonged under the circumstances set forth below and do declare:

1. If at any time I should (check each option desired):

- have a terminal condition,
- become in a coma with no reasonable expectation of regaining consciousness, or
- become in a persistent vegetative state with no reasonable expectation of regaining significant cognitive function,

as defined in and established in accordance with the procedures set forth in paragraphs (2), (9) and (13) of Code Section 31-32-2 of the Official Code of Georgia Annotated, I direct that the application of life-sustaining procedures to my body

(check the option desired):

- including nourishment and hydration,
- including nourishment but no hydration, or
- excluding nourishment and hydration,

be withheld or withdrawn and that I be permitted to die;

- 2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this living will 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;
- 3. I understand that I may revoke this living will at any time;
- 4. I understand the full import of this living will, and I am at least 18 years of age and am emotionally and mentally competent to make this living will; and
- 5. If I am a female and I have been diagnosed as pregnant, this living will shall have no force and effect unless the fetus is not viable and I indicate by initialing after this sentence that I want this living will to be carried out. \_\_\_\_\_ (Initial)

**Declarant Signature:**

Signed: \_\_\_\_\_

(City) \_\_\_\_\_ (County) \_\_\_\_\_ (State of Residence) \_\_\_\_\_

**MEDICAL CENTER OF CENTRAL GEORGIA**

**Living Will**

**A** 0102-01/02-01/98 s/s

Patient Identification
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I hereby witness this living will and attest that:

- (1) The declarant is personally known to me and I believe the declarant to be at least 18 years of age and of sound mind:
- (2) I am at least 18 years of age;
- (3) To the best of my knowledge, at the time of the execution of this living will, I:
  - (A) Am not related to the declarant by blood or marriage;
  - (B) Would not be entitled to any portion of the declarant's estate by any will or by operation of law under the rules of descent and distribution of this state;
  - (C) Am not the attending physician of declarant or an employee of the attending physician or an employee of the hospital or skilled nursing facility in which declarant is a patient;
  - (D) Am not directly financially responsible for the declarant's medical care
  - (E) Have no present claim against any portion of the estate of the declarant;
- (4) Declarant has signed this document in my presence as above instructed, on the date above first shown.

Witness: \_\_\_\_\_

Address: \_\_\_\_\_

Witness: \_\_\_\_\_

Address: \_\_\_\_\_

Additional witness required when living will is signed in a hospital or skilled nursing facility.

I hereby witness this living will and attest that I believe the declarant to be of sound mind and to have made this living will willingly and voluntarily.

Witness: \_\_\_\_\_

Medical director of skilled nursing facility or staff physician not participating in care of the patient or chief of the hospital medical staff or staff physician or hospital designee not participating in care of the patient.

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