

State of Indiana
Life-Prolonging Procedures Declaration

**Declaration B:
To Request the Use of Life-Prolonging Procedures**

Declaration made this _____ day of _____
(day) (month, year)

I, _____,
(print name)

being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed _____

(City, County, and State of Residence)

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____



State of Indiana Living Will Declaration

Declaration A: To Withhold or Withdraw Life-Prolonging Procedures

Declaration made this _____ day of _____
(day) (month, year)

I, _____,
(name)

being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that:

- (1) I have an incurable injury, disease, or illness;
- (2) My death will occur within a short time; and
- (3) The use of life prolonging 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I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under Indiana Code 16-36-1-7 or Indiana Code 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal. I understand the full import of this declaration.

Signed _____

(City, County, and State of Residence)

The declarant has been personally known to me, and I believe (him/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 a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____

Date _____

Witness _____

Date _____



Indiana Appointment of Health Care Representative

I, _____
(print name)

of _____
(address)

hereby appoint _____
(name of health care representative)

(address)

(home telephone number) (work telephone number)

as my health care representative to make health care decisions for me when, and only when, I cannot make my own decisions or communicate what I want done. My health care representative may not appoint anyone else to make decisions for me.

I grant my health care representative the following powers concerning my health care:

- (1) to make all the necessary arrangements for my care with any hospital, home care agency, psychiatric treatment facility, nursing home, hospice or other health care organization;
- (2) to employ or discharge health care personnel as he or she deems necessary for my physical, mental and emotional well-being;
- (3) to move me into or out of any institution or State in order to comply with my health care directive or the decisions of my health care representative;
- (4) to request, receive and review any information about my physical or mental health or my personal affairs, including medical and hospital records, and to execute any releases that may be required to obtain such information;
- (5) to make decisions about organ donation;
- (6) to request an autopsy;
- (7) to make arrangements for the disposition of my body; and
- (8) to take legal action, if needed, to do what I have directed.

[If you DO NOT want the person (health care representative) you name to be able to do any of the above things, draw a line through it and put your initials at the end of the line]

In the event the person I appoint above is unable, unwilling or unavailable to act as my health care representative, I hereby appoint:

(name of alternate health care representative)

of _____
(address)

(home telephone number) (work telephone number)

as my alternate health care representative. *(If you DO NOT want to name an alternate, write "none.")*



Indiana Appointment of Health Care Representative

In addition to the powers granted above, I appoint my health care representative to make decisions in my best interest concerning the consent, withdrawal or withholding of life-prolonging treatment. If I have completed the attached Declaration A or B, I expect my representative to be guided by my directions as stated in this form. My health care representative also is authorized to consent, refuse, or withdraw consent to any care, treatment, service or procedure (including artificially supplied nutrition and/or hydration/tube feeding) used to maintain, diagnose or treat a physical or mental condition.

If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative believes that certain health care is not or would not be beneficial, or that such health care would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other health caregivers. As appropriate, my health care representative also may discuss this decision with my family and others to the extent they are available.

I, _____, the principal, sign
(principal name)

my name to this document this _____ day of _____, 20_____, and do hereby declare to the undersigned witness that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am eighteen (18) years of age or older, of sound mind, and under no constraint or undue influence.

(principal signature)

Witness _____ Date _____

Witness _____ Date _____

