

KANSAS LIVING WILL DECLARATION

The Living Will is a declaration to your physician and other health care providers. It describes your wishes. It does not serve the same purpose as a Do-Not-Resuscitate order (DNR). In an emergency, resuscitation will be provided unless a DNR order also has been written.

The "Living Will" Declaration has been authorized in Kansas in order to protect the rights of patients even after they are no longer able to participate actively in making decisions. You have the right to make a declaration instructing your physician to withhold or withdraw life sustaining procedures in the event you have a terminal condition.

Any adult person may execute a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The declaration shall be:

- 1. In writing.*
- 2. Signed by you or signed by another person in your presence and by your expressed direction.*
- 3. Dated.*
- 4. Signed in the presence of two witnesses at least 18 years of age neither of whom shall be the person who signed the declaration on your behalf. The witnesses may not be related to you by blood or marriage, entitled to any portion of your estate, or directly financially responsible for your medical care or acknowledged before a notary public.*

It is your responsibility to notify your attending physician of the existence of the declaration. The physician shall make a copy of the declaration part of your medical records.

I, _____, being of sound mind, willfully and voluntarily making known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration 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.

I understand the full import of this declaration and I am emotionally and mentally competent to make this decision.



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

Signature: X _____

Address: (street) _____

(city) _____ (state,zip) _____

This document must be witnessed by two individuals or acknowledged by a notary public.

Notary Public:

STATE OF _____ COUNTY OF _____ - ____ SS:

This instrument was acknowledged before me this _____ day of _____ (month, year)

Signature of Notary: _____

My appointment expires: _____

OR

Witnesses:

The declarant has been personally known to me and I believe the declarant 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 related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly responsible for declarant's medical care.

Name: _____

Name: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip: _____

