

LIVING WILL
DECLARATION
OF

If I should lapse into a persistent vegetative state or 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, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

Declarant Signature

Signed this _____ day of _____, 20____

Social Security Number: _____ Date of Birth _____

Address: _____ Signature: _____

City/State: _____

The declarant voluntarily signed this writing in my presence.

Signature of witness: _____ Printed name/Date: _____

Signature of witness: _____ Printed name/Date: _____

-OR-
NOTARY

The declarant voluntarily signed this document in my presence.

STATE OF NEBRASKA)
)ss.
COUNTY OF _____)

Notary Public