

INSTRUCTIONS FOR COMPLETING THE KENTUCKY LIVING WILL FORM

The Living Will form should be used to let your physician and your family know what kind of life-sustaining treatments you want to receive if you become terminally ill or permanently unconscious and are unable to make your own decisions. This form should also be used if you would like to designate someone to make those healthcare decisions for you should you become unable to express your wishes.

NOTE: You may fill out all or part of the form according to your wishes. Keep in mind that filling out this form is not required for any type of healthcare or any other reason. Filling out this form should solely be a personal decision.

1. Read over all information carefully before filling out any part of the form.
2. At the top of the form in the designated area, print your full name and birth date.
3. The first section of the form on page one relates to designating a "Health Care Surrogate." Fill this section out if you would like to choose someone to make your healthcare decisions for you should you become unable to do so yourself. When choosing a surrogate, remember that the person you name will have the power to make important treatment decisions. Choose the person best qualified to be your health care surrogate. Also, consider picking a back-up person, in case your first choice isn't available when needed. Be sure to tell the person that you have named them a surrogate and make sure that the person understands what's most important to you. **Do not complete this section if you do not wish to name a surrogate.**
4. The next section of the form is the "Living Will Directive." Fill out this section to identify what kinds of life-sustaining treatments you want to receive should you become terminally ill or permanently unconscious.

Life Prolonging Treatment

Under this bolded section on page one, you may designate whether or not you wish to receive treatment (such as a life support machine), and be permitted to die naturally, with only the administration of medication or treatment deemed necessary to alleviate pain. If you do not want treatment, except for pain, and would like to die naturally, check and initial the first line. If you want life-sustaining treatment, check and initial the second line. Check and initial only one line.

Nourishment and/or Fluids

Under this bolded section on page two, you may designate whether or not you wish to receive artificially provided food, water, or other artificially provided nourishment or fluids (such as a feeding tube). If you do not want to receive artificial nourishment or fluids, check and initial the first line. If you want to receive nourishment and/or fluids, check and initial the second line. Check and initial only one line.

Surrogate Determination of Best Interest

Important: This section cannot be completed if you have completed the two previous bolded sections. Under this bolded section on page two, IF you have designated a person as your surrogate in the first section, you may allow that person to make decisions for you regarding life-sustaining treatments and/or nourishment. Check and initial this line **ONLY** if you wish to allow your surrogate to make decisions for you and if you do not want to detail your specific life-sustaining wishes on this form.

Organ/Tissue Donation

Under this bolded section on page two, you may designate whether or not to donate your all or any part of your body upon your death. If you wish to donate all or part of your body, check and initial the first line. If you do not want to donate all or part of your body, check and initial the second line. Check and initial only one line.

5. On page three, you will sign and date the form. Sign and date the form **in the presence of two witnesses over the age of 18 OR in the presence of a Notary Public.**

The following people CANNOT be a witness to or serve as a notary public:

- a) A blood relative of yours;
 - b) A person who is going to inherit your property under Kentucky law;
 - c) An employee of a health care facility in which you are a patient (unless the employee serves as a notary public);
 - d) Your attending physician; or
 - e) Any person directly financially responsible for your health care.
6. Once you have filled out the Living Will and either signed it in the presence of witnesses or in the presence of a notary public, give a copy to your personal physician and any contacts you have listed in the Living Will. A copy of any Living Will should be put in your medical records. Remember, you are responsible for telling your hospital or nursing home that you have a Living Will. Do not send your Living Will to the Office of the Attorney General.

KENTUCKY LIVING WILL DIRECTIVE AND HEALTH CARE SURROGATE DESIGNATION OF

(PRINTED NAME)

(DATE OF BIRTH)

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious have been indicated by checking and initialing the appropriate lines below.

HEALTH CARE SURROGATE DESIGNATION

By checking and initialing the line below, I specifically:

_____ (check box and initial line, if you desire to name a surrogate)

Designate _____ as my health care surrogate(s) to make health care decisions for me in accordance with this directive when I no longer have decisional capacity. If _____ refuses or is not able to act for me, I designate _____ as my health care surrogate(s).

Any prior designation is revoked.

LIVING WILL DIRECTIVE

If I do not designate a surrogate, the following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below. By checking and initialing the lines below, I specifically:

Life Prolonging Treatment (check and initial only one)

_____ (check box and initial line, if you desire the option below)
Direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

_____ (check box and initial line, if you desire the option below)
DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

Nourishment and/or Fluids (check and initial only one)

_____ (check box and initial line, if you desire the option below)
Authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

LIVING WILL DIRECTIVE — CONTINUED

_____ (check box and initial line, if you desire the option below)
DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

Surrogate Determination of Best Interest

NOTE: If you desire this option, DO NOT choose any of the preceding options regarding Life Prolonging Treatment and Nourishment and/or Fluids

_____ (check box and initial line, if you desire the option below)
Authorize my surrogate, as designated on the previous page, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

Organ/Tissue/Eye Donation

I certify that I am eighteen (18) years of age or older and of sound mind, and that upon my death, I hereby give:

Check appropriate boxes and initial the line beside that box:

_____ Any needed organs, tissues, and eye/corneas

OR

The following organs or tissues only (check and initial all that apply):

_____ All needed organs

_____ All needed tissues

_____ Corneas

_____ Eyes

_____ Other

OR

_____ Only the specified organs/tissues as listed:

Organs that can be donated: heart, lungs, liver, pancreas, kidneys, and small bowel.

Tissues that can currently be donated: skin (outermost layer from lower trunk and abdomen), bone, heart valves, leg veins, pericardium, vertebral bodies.

Eye donation can be the corneas (outer most layer), the sclera (shell), or the entire eye.

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

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

Signed this _____ day of _____, 20____

(signature and address of the grantor)

Have two adults witness your signature OR have signature notarized.*

In our joint presence, the grantor, who is of sound mind and eighteen (18) years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor.

(signature and address of witness)

(signature and address of witness)

OR

COMMONWEALTH OF KENTUCKY, _____ County

Before me, the undersigned authority, came the grantor who is of sound mind and eighteen (18) years of age or older, and acknowledged that he/she voluntarily dated and signed this writing or directed it to be signed and dated as above.

Done this _____ day of _____, 20____

Signature of Notary Public

Date commission expires

** None of the following shall be a witness to or serve as a notary public or other person authorized to administer oaths in regard to any advance directive made under this section:*

- a) A blood relative of the grantor;*
- b) A beneficiary of the grantor under descent and distribution statutes of the Commonwealth;*
- c) An employee of a health care facility in which the grantor is a patient, unless the employee serves as a notary public;*
- d) An attending physician of the grantor; or*
- e) Any person directly financially responsible for the grantor's health care.*

NOTICE: Execution of this document restricts withholding and withdrawing of some medical procedures. Consult Kentucky Revised Statutes or your attorney.

A person designated as a surrogate pursuant to an advance directive may resign at any time by giving written notice to the grantor; to the immediate successor surrogate, if any; to the attending physician; and to any health care facility which is then waiting for the surrogate to make a health care decision.

