PLEASE BE SURE YOU READ THE FORM CAREFULLY AND UNDERSTAND IT BEFORE YOU COMPLETE AND SIGN IT

DECLARATION TO HEALTH CARE PROFESSIONALS (WISCONSIN LIVING WILL)

I, _____

being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician, physician assistant or advanced practice registered nurse, honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a **TERMINAL CONDITION**, as determined by a physician, physician assistant, or advanced practice registered nurse, who have personally examined me, and if a physician who has also personally examined me agrees with that determination, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

   ☐ YES, I want feeding tubes used if I have a terminal condition.

   ☐ NO, I do not want feeding tubes used if I have a terminal condition.

   If you have not checked either box, feeding tubes will be used.

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by a physician, physician assistant, or advanced practice registered nurse who have personally examined me, and if a physician who has also personally examined me agrees with that determination, the following are my directions regarding the use of life-sustaining procedures:

   ☐ YES, I want life-sustaining procedures used if I am in a persistent vegetative state.

   ☐ NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

   If you have not checked either box, life-sustaining procedures will be used.

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by a physician, physician assistant, or advanced practice registered nurse who has personally examined me, and if a physician who has also personally examined me agrees with that determination, the following are my directions regarding the use of feeding tubes:

   ☐ YES, I want feeding tubes used if I am in a persistent vegetative state.

   ☐ NO, I do not want feeding tubes used if I am in a persistent vegetative state.

   If you have not checked either box, feeding tubes will be used.

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

ATTENTION: You and the 2 witnesses must sign the document at the same time.

Signed_____ **Date**_____

Address_____ **Date of Birth**_____

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness **Signature**_____ **Date Signed**_____

Print Name_____

Witness **Signature**_____ **Date Signed** _____

Print Name_____

DIRECTIVES TO ATTENDING PHYSICIAN, PHYSICIAN ASSISTANT, OR ADVANCED PRACTICE REGISTERED NURSE

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when a physician and another physician, physician assistant, or advanced practice registered nurse, one of whom is the attending health care professional, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

2. The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless you believe that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed.

3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician, physician assistant, or advanced practice registered nurse who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

* * * * *

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document: