Tennessee Living Will

Under Federal and state law, I have the right to decide what medical treatments I receive. After talking about my wishes with my doctor and family, I want to say:

(1) That if I have a condition that will lead to my death and I can't recover from this condition, I want to die naturally without treatment designed to delay my death. I only want treatment to keep me pain-free.

(2) That if I am in a coma or am persistently unconscious, and my doctors feel that this condition is not likely to improve, I want any medical treatment that will keep me from being in distress, but I don't want treatment intended only to keep my body alive.

In these two cases, I only want treatments to make me clean, comfortable, and pain free, even if treating me in this way makes me pass away sooner.

If either of these two cases apply, *(Place an x next to either WANT or DON'T WANT for each following choice.)*

1. I ____**WANT** / ____ **DON'T WANT** cardiopulmonary resuscitation treatments which h make my heart and lungs continue to work. These treatments include CPR, drugs, electric shock, and artificial breathing.

2. If I can eat and drink, I want normal food and water.
   After that, I ____**WANT** / ____**DON'T WANT** to get food and water through tubes.
   These could include tubes in my veins, nose, throat, or stomach.

I have a specific attitude toward organ donation, and it is: *(Select one of these choices)*

____ I want to donate any and all useful organs and tissues. After I am declared dead according to Tennessee State Law, keep my body on artificial support until my organs are harvested.

____ I want to donate these organs: _____

____ I don't want to donate any organs or tissues.

I ____ **HAVE** / ____ **DON'T HAVE a Durable Power of Attorney for Healthcare. If I do, it can be retrieved by calling my agent, _____, at _____**

I understand what I am signing, and am completing this living will of my own accord. I know that I can always change my mind, but if I don't , my doctors and family must honor it. I am emotionally and mentally competent to make this declaration, and accept full responsibility for my actions.

Date:_____ Signature _____

Date: _____ Print Name _____

WITNESS' STATEMENT: We saw this person sign this document. We believe that he or she is mentally competent, understands the action and any potential consequences, and signed it freely. We are not family members, we are not doctors, nurses, or employees of this healthcare facility, and we won't receive anything from this person's estate. We also have no claims upon this person's estate.

Witness #1 _____ Witness #2 _____