INSTRUCTIONS
To Living Will

A living will is a written document which directs your physician to withhold or stop life-sustaining medical procedures if you develop a terminal condition and can't state your wishes at the time a decision about those kinds of procedures must be made.

Rhode Island law suggests a form of living will but does not require its exclusive use. If you decide to sign a living will, you may use the form supplied with these instructions or make your own living will form. If you use this form, please read and follow these instructions carefully.

1. Print your name in the first line of the form.

2. Place a check mark in the third paragraph to indicate whether you want artificially-administered nutrition and hydration (food and water) to be stopped or withheld like any other life-sustaining treatment. Remember, if you do not want artificial nutrition and hydration, your living will must say so.

3. Complete the day, month and year that you sign at the bottom of this form.

4. Sign your name on the signature line (or if you are unable to do so, have someone do it for you) before two (2) witnesses who know you and are at least 18 years old.

5. Print your address on the address line.

6. Have the two (2) witnesses sign their names and print their addresses where indicated below your signature. The witnesses may not be related to you by blood or marriage.

7. Give a signed copy of your living will to your physician for your medical records.

   Remember, you may revoke your living will at any time simply by telling your physician not to follow it.

NOTE: This information is provided to make you generally aware of Rhode Island law about living wills and is not intended as legal advice for your particular situation. For legal advice about living wills or your health care rights, you should consult with an attorney.

STATE OF RHODE ISLAND

CHAPTER 23-4.11
A declaration may, but need not, be in the following form:

RIGHTS OF THE TERMINALLY ILL ACT

DECLARATION

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

If I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

This authorization includes ☐
does not include ☐

the withholding or withdrawal of artificial feeding. *(check only one box above)*

Signed this _____ day of _____, _____.

_____
Signature of Declarant

_____
Address

The Declarant is personally known to me and voluntarily signed this document in my presence. I am not related to the Declarant by blood or marriage.

_____ _____
Witness Witness

_____ _____
Address Address

LIVING WILL

TO: My family, physicians and all
those concerned with my care

I, presently residing at_____,_____, and being an adult of sound mind, make this declaration as a directive to be followed if for any reason I become unable to make or communicate decisions regarding my medical care.

I do not want medical treatment that will keep me alive if I am unconscious and there is no reasonable prospect that I will ever be conscious again (even if I am not going to die soon in my medical condition) or if I am near death from an illness or injury with no reasonable prospect of recovery. The procedures and treatment to be withheld and withdrawn include, without limitation, surgery, antibiotics, cardiac and pulmonary resuscitation, respiratory support, and artificially administered feeding and fluids. I direct that treatment be limited to measures to keep me comfortable and to relieve pain, even if such measures shorten my life.

[OPTIONAL] I wish to live out my last days at home rather than in a hospital, if it does not jeopardize the chance of my recovery to a meaningful and conscious life and does not impose an undue burden on my family.

[OPTIONAL] If, upon my death, any of my tissue or organs would be of value for transplantation, therapy, advancement of medical or dental science, research, or other medical, educational or scientific purpose, I freely give my permission to the donation of such tissue or organs.

These directions are the exercise of my legal right to refuse treatment. Therefore, I expect my family, physicians, health care facilities and all concerned with my care to regard themselves as legally and morally bound to act in accordance with my wishes, and in so doing to be free from any liability for having followed my directions.

IN WITNESS WHEREOF, I have executed this declaration, as my free and voluntary act and deed, this ____day of_____, 20__.

_____

WITNESS:

We, the undersigned witnesses, each hereby attest and declare under penalty of perjury under the laws of the Commonwealth of Massachusetts that: (1) the foregoing instrument was personally signed by in my presence, and thereupon I, at his request and in his/her presence and in the presence of the other witnesses, have hereunto

subscribed my name as a witness; (2) I did not sign the above signature of (YOUR NAME) for or at his/her direction; (3) I personally know (YOUR NAME) and believe him/her to be of sound mind and under no constraint, duress, fraud or undue influence; (4) I am not related to (YOUR NAME) by blood, marriage or adoption; (5) I am not entitled (to the best of my knowledge and belief) to any portion of the estate of (YOUR NAME) upon his/her death under any will or codicil of (YOUR NAME) or by operation of law; (6) I do not have any present or inchoate claim against any portion of the estate of (YOUR NAME); (7) I do not have any financial responsibility for the medical care of (YOUR NAME); (8) I am not a physician or an employee of any physician, and I am not an operator or employee of, or patient in, any hospital, health care provider, residential care facility, community care facility or similar institution; and (9) I am at least 18 years of age.

Dated: _____, 20__

_____

residing at

_____

_____

_____

residing at

_____

_____