DECLARATION AND LIVING WILL

A DECLARATION GOVERNING THE WITHHOLDING OR
WITHDRAWAL OF LIFE SUSTAINING TREATMENT

I, _____ being of sound mind and eighteen (18) or more years of age, intentionally and voluntarily declare:

1. If I should 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, I direct my attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

2, If possible, I wish to participate in decisions regarding my medical treatment and procedures which may be used to prolong my life. It is my intention that this declaration be honored by my family and attending physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of my refusal.

3. If I wish to include the following state, I MUST INITIAL the statement in the box provided:

I direct my attending physician not to withhold or withdraw artificial nutrition and hydration by way of the gastrointestinal tract if such withholding or withdrawal would result in my death by starvation or dehydration. (_____).

If I have been found to be pregnant, and that fact is known to my physician, and it is probable that the fetus will develop to the point of live birth with the continued application of life sustaining treatment, this declaration is void during the course of my pregnancy.

This decision is made after careful consideration and reflection. I understand the full import of this declaration and I am emotionally and mentally competent to execute such declaration. I direct that all legal means be taken to support my choice. In the carrying out of wishes as stated, I release and hold harmless all physicians, their employees, any hospital or other health care facility, their employees and other health care personnel, and members of my family from all suits, claims or demands of every kind and character as a result of any action taken under this declaration.

Signed this _____ day of _____, 20_____.

Signature: _____ Address: _____

The declarant voluntarily signed this document in my presence (Witness or Notary):
(Declaration **may not** be witnessed by an employee or volunteer of Saint Mary's Regional Medical Center)

Witness: _____ Address: _____

Witness: _____ Address: _____

State of Nevada }
ss
County of _____ }

On this _____ day of _____, in the year _____, before me, _____a Notary Public in and for said state, personally appeared _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who executed the above instrument, and acknowledged to me that he/she executed the same for purposes stated therein. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____

NOTARY PUBLIC in and for said County and State

60103 (12/28/06)