QUESTIONNAIRE FOR LIVING WILL

The person you choose to be your attorney-in-fact - who shall act as my agent to make health care decisions for me as authorized in the document.

Full Legal Name:

Relationship:

Address:

Telephone:

If the person named above is not willing, able, or reasonably available to make a health-care decision for you, this person is designated as your first alternate agent:

Full Legal Name:

Relationship:

Address:

Telephone:

If both of the persons named above are not willing, able, or reasonably available to make a health-care decision for you, this person is designated as your first alternate agent:

Full Legal Name:

Relationship:

Address:

Telephone:

If you are in a permanently unconscious state, have an incurable and irreversible condition that will result in my death within a relatively short time, you become unconscious and, to a reasonable degree of medical certainty, you will not regain consciousness, and the likely risks and burdens of treatment would outweigh the expected benefits, is it your desire that extraordinary medical treatment procedures be withheld, even if it hastens your death?

Yes (withhold) ___

No (do not withhold) ___

If you are in a permanently unconscious state, have an incurable and irreversible condition that will result in my death within a relatively short time, you become unconscious and, to a reasonable degree of medical certainty, you will not regain consciousness, and the likely risks and burdens of treatment would outweigh the expected benefits, do you want artificial nutrition and hydration provided to you?

Yes ___

No___

If you are in a permanently unconscious state, have an incurable and irreversible condition that will result in my death within a relatively short time, you become unconscious and, to a reasonable degree of medical certainty, you will not regain consciousness, and the likely risks and burdens of treatment would outweigh the expected benefits, do you want treatment provided to you to alleviate pain or discomfort, even if it hastens my death.

Yes ___

No___

If you are terminally ill or permanently unconscious, do you want Cardiopulmonary Resuscitation ("CPR") performed on you in the event you stop breathing or your heart fails.

Yes ___

No___

Upon your death, do you wish to donate any needed organs, tissues, or parts.

Yes ___

No___

If "Yes" to the question above, your organ donation is for the following purposes (mark yes on each line that applies):

_____ Transplant

_____ Therapy

_____ Research

_____ Education

_____ Any purpose that may be of benefit.

List the following for your primary physician:

Name of Physician:

Address:

Telephone:

If the physician listed above is not willing, able, or reasonably available to act as my primary physician, provide information for another physician:

Name of Physician:

Address:

Telephone:

Any other statements, wishes or directions that you wish to make in this document?: