

## NEW YORK LIVING WILL

This Living Will has been prepared to conform to the law in the State of New York, as set forth in the case *In re Westchester County Medical Center*, 72 N.Y. 2d 517 (1988). In that case, the Court established the need for “clear and convincing” evidence of a patient’s wishes and stated that the “ideal situation is one in which the patient’s wishes were expressed in some form of writing, perhaps a ‘Living Will’.”

**This declaration is intended to serve as a guide to assist my duly appointed health care agent in making medical decisions on my behalf. However, it is not intended to limit my health care agent’s sole discretion to interpret this document and to make medical decisions in good faith after full consideration of my medical condition and prognosis. If my health care agent is unable to serve for any reason, my attending physicians shall comply with my directions.**

I, \_\_\_\_\_, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery.

These instructions apply if I am a) in a terminal condition; b) permanently unconscious; or c) minimally conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

While I understand that I am not legally required to be specific about future treatments, if I am in the condition(s) described above, I feel especially strongly about the following forms of treatment:

- (  ) I do not want cardiac resuscitation, and I want my healthcare provider to issue a DNR.
- (  ) I do not want mechanical respiration.
- (  ) I do not want artificial nutrition and/or hydration.
- (  ) I do not want antibiotics.
- (  ) I do not want any other painful or invasive treatment that will result in prolonging my life.
- (  ) I do want maximum pain relief.

Other directions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Statement by Witnesses** (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)

I declare that the person who signed this document was either personally known to me and appeared to be of sound mind and acting of his/her/their own free will, and that he/she/they signed (or asked another to sign for him/her/them) this document in my presence; or was in our presence over a live video conference that allowed for direct interaction between us and the person who signed this document pursuant to Executive Order 202.14, where all parties were present at the same time via the live video conference, and where the person who signed this document was personally known by me or presented a valid photo ID during the video conference and appeared to be of sound mind and acting of his/her/their own free will, and that he/she/they signed (or asked another to sign for him/her/them) this document in our presence during the video conference.

Date: \_\_\_\_\_

Witness 1 (Signature): \_\_\_\_\_

Witness 1 (Print name): \_\_\_\_\_

Witness 1 (Address): \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Witness 2 (Signature): \_\_\_\_\_

Witness 2 (Print name): \_\_\_\_\_

Witness 2 (Address): \_\_\_\_\_

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