DECLARATION CONCERNING MEDICAL CARE
(LIVING WILL)

I, _____, of _____,

_____ County, Pennsylvania, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent.

I believe that life is a precious gift from God. I understand and believe, as a Catholic, that I may never choose to directly cause or hasten my death. I believe that euthanasia is the deliberate act of taking the life of another, whether by active intervention or by omitting an action with the intention of causing death. I believe that euthanasia constitutes an unwarranted destruction of human life and is never morally permissible. I also believe that suicide and assisted suicide are never morally permissible.

I believe that God intended for my life to be lived for His glory and my salvation. I know, too, that my earthly goal is to be united with God for eternal life. Therefore, I do not need to resist death if medical treatment is futile or disproportionately burdensome. My duly appointed health care agents may refuse medical treatments as long as doing so is consistent with the authoritative teaching of the Catholic Church.

This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated herein. The following

health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the physical and mental capacity to understand, make or communicate my own treatment decisions.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition, have an end-stage medical condition or in a state of permanent unconsciousness. I believe that I do not have to use ethically extraordinary or disproportionate medical treatments for sustaining life if they are excessively burdensome or do not offer any reasonable hope of benefit. I understand that this belief is consistent with authoritative Catholic teaching.

If I fall terminally ill, I ask that I be told so that I might prepare myself for death. I direct that a Catholic priest be contacted to attend to my spiritual needs so that I many receive the Sacraments of Reconciliation and the Anointing of the Sick, Viaticum and be supported by prayer.

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 life-sustaining treatment, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming. Pain medication should never be administered with the purpose of hastening my death.

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious, such as in an irreversible coma or an irreversible vegetative state, and there is no realistic hope of significant recovery, all of the following apply:

I ( ) do ( ) do not want cardiac resuscitation.

I ( ) do ( ) do not want mechanical respiration.

I ( ) do ( ) do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

I ( ) do ( ) do not want blood or blood products.

I ( ) do ( ) do not want any form of surgery or invasive diagnostic tests.

I ( ) do ( ) do not want kidney dialysis.

I ( ) do ( ) do not want chemotherapy.

I ( ) do ( ) do not want radiation treatment.

I ( ) do ( ) do not want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

I designate my _____ , _____ , as my health care agent to make medical treatment decisions for me and follow these instructions if I should be incompetent and in a terminal condition, have an end-stage medical condition or in a state of permanent unconsciousness.

Should my health care agent, _____ , be unable or unwilling to serve in the within capacity, at any time, I designate my

_____ , _____ , as my alternate health care agent, with all the powers and duties herein expressed to my health care agent.

Should my alternate health care agent, _____, be unable or unwilling to serve in the within capacity, at any time, I designate my _____ , _____ , as my second alternate health care agent, with all the powers and duties herein expressed to my health care agents.

Pennsylvania law protects my health care agents and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agents' directions. On behalf of myself, my executors, administrators and heirs, I further hold my health care agents and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agents' authority or in following my treatment instructions.

Having carefully read this document, I have signed it this _____ day of _____ , 2018, revoking all previous health care powers of attorney and health care treatment instructions.

_____

Witness: _____
Address:

Witness: _____
Address: