

How to use the Pennsylvania Will to Live Form

SUGGESTIONS AND REQUIREMENTS

1. This document allows you to designate (name) a health care power of attorney -- someone who will make health care decisions for you whenever you are unable to make them for yourself. It also allows you to give instructions about medical treatment decisions that the health care agent must follow.
2. In order to execute this document, you must be eighteen years or older, have graduated from high school or have married.
3. To properly designate a health care power of attorney through this document, you must sign and date this document in the presence of two witnesses each of whom is at least 18 years old. (If you are unable to sign and date the document yourself, you may direct someone to do it for you in your presence.) The two witnesses must sign the document in your presence and in each other's presence.
4. The witnesses must be at least 18 years old. If someone signs the document on your behalf or at your direction, that person may not serve as a witness. A health care provider and its agent may not sign a health care power of attorney on your behalf and at your direction if the health care provider or agent provides health care services to you.
5. It is helpful to designate successor health care agent(s), to take over if your first choice is unable to serve. There is space on the form for you to designate two successor health care agents.
6. You should give your doctor a copy of this document. The law requires the doctor to make it a part of your medical record, and, if unwilling to comply with it, to tell you that promptly. It will not be effective unless you give a copy to your doctor.
7. Your health care agent's authority takes effect only when you no longer have the capacity to make and communicate your own health care decisions.
8. The document will remain in effect until you revoke (cancel) it. You may revoke this document at any time, without regard to your mental or physical condition. A revocation takes effect as soon as you tell the attending physician or other health care provider orally or in writing, or as soon as a witness to your revocation does so.
9. This type of document has been authorized by 20 Pa.Cons. Stat. §§ 5421 through 5471 (2010).
10. **BEFORE SIGNING THE DOCUMENT READ IT CAREFULLY.**

11. You should periodically review this document to be sure it complies with your wishes. Before making any changes, be aware that it is possible that the statutes controlling this document have changed since this form was prepared. Contact the Will to Live Project by visiting www.nrlc.org (click on “Will to Live”) or an attorney to determine if this form can still be used.
12. If you have any questions about this document or want assistance filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit www.nrlc.org

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Clerical Changes Made 05/11

**Pennsylvania Durable Health Care Power of Attorney and Health Care
Treatment Instructions
WILL TO LIVE FORM**

I, _____
(your name)

Address _____

(your address)

Telephone _____,
(your telephone number(s))

being of sound mind, willfully and voluntarily make this declaration, which reflects my firm and settled commitment regarding the circumstances described below, designate:

(agent's name) _____
(agent's address) _____

(agent's phone number(s)) _____

as my health care agent to make any health care decisions for me as authorized in this document consistent with the instructions below. If the person I designate above refuses or is not able to act for me, I designate the following persons (each to act alone and successively, in the order named):

A. First Successor Agent
(successor agent's name) _____
(successor agent's address) _____

(successor agent's phone number(s)) _____

B. Second Successor Agent
(second successor agent's name) _____
(second successor agent's address) _____

(second successor agent's phone number(s)) _____

as my health care agent(s) to make any health care decisions for me as authorized in this document consistent with the instructions below.

This designation shall become effective when my attending physician determines that I am incompetent and in a terminal condition or in a state of permanent unconsciousness as specified by Pennsylvania law.

Any prior designation is revoked.

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care surrogate(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care attorney in fact to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

—all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care surrogate to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my surrogate, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

B. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:
(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

WHEN I AM TERMINALLY ILL

C. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

D. OTHER SPECIAL CONDITIONS:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

IF I AM PREGNANT

E. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care surrogate(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

Signature of Principal

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

Signature _____

Address _____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

In our joint presence, the declarant, who is of sound mind and eighteen years of age, or older, voluntarily signed and dated this writing or directed it to be dated and signed for the declarant.

Signature of First Witness _____

Address _____

Signature of Second Witness _____

Address _____

NOTARIZATION (OPTIONAL)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this _____ day of _____, _____, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of _____ the day and year first above written.

Notary Public

My commission expires

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