Kentucky Living Will Directive and Health Care Surrogate Designation of

_____
(PRINTED NAME)

_____
(DATE OF BIRTH)

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious have been indicated by checking and initialing the appropriate lines below.

Health Care Surrogate Designation

By checking and initialing the line below, I specifically:

☐ _____ (check box and initial line, if you desire to name a surrogate)

Designate _____ as my health care surrogate(s) to make health care decisions for me in accordance with this directive when I no longer have decisional capacity. If _____ refuses or is not able to act for me, I designate _____ as my health care surrogate(s).

Any prior designation is revoked.

Living Will Directive

If I do not designate a surrogate, the following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below. By checking and initialing the lines below, I specifically:

Life Prolonging Treatment (check and initial only one)

☐ _____ (check box and initial line, if you desire the option below)
Direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

☐ _____ (check box and initial line, if you desire the option below)
DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

Nourishment and/or Fluids (check and initial only one)

☐ _____ (check box and initial line, if you desire the option below)
Authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

Living Will Directive — Continued

☐ _____ (check box and initial line, if you desire the option below)
DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

Surrogate Determination of Best Interest

NOTE: If you desire this option, DO NOT choose any of the preceding options regarding Life Prolonging Treatment and Nourishment and/or Fluids

☐ _____ (check box and initial line, if you desire the option below)
Authorize my surrogate, as designated on the previous page, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

Organ/Tissue/Eye Donation

I certify that I am eighteen (18) years of age or older and of sound mind, and that upon my death, I hereby give:

Check appropriate boxes and initial the line beside that box:

☐ _____ Any needed organs, tissues, and eye/corneas

OR

The following organs or tissues only (check and initial all that apply):

☐ _____ All needed organs

☐ _____ All needed tissues

☐ _____ Corneas

☐ _____ Eyes

☐ _____ Other

OR

☐ _____ Only the specified organs/tissues as listed:

_____

_____

_____

Organs that can be donated: heart, lungs, liver, pancreas, kidneys, and small bowel.

Tissues that can currently be donated: skin (outermost layer from lower trunk and abdomen), bone, heart valves, leg veins, pericardium, vertebral bodies.

Eye donation can be the corneas (outer most layer), the sclera (shell), or the entire eye.

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed this _____ day of _____, 20____

_____

(signature and address of the grantor)

Have two adults witness your signature OR have signature notarized.*

In our joint presence, the grantor, who is of sound mind and eighteen (18) years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor.

_____

(signature and address of witness)

_____

(signature and address of witness)

OR

COMMONWEALTH OF KENTUCKY, _____ County

Before me, the undersigned authority, came the grantor who is of sound mind and eighteen (18) years of age or older, and acknowledged that he/she voluntarily dated and signed this writing or directed it to be signed and dated as above.

Done this _____ day of _____, 20_____

_____ _____

Signature of Notary Public Date commission expires

** None of the following shall be a witness to or serve as a notary public or other person authorized to administer oaths in regard to any advance directive made under this section:*

a) A blood relative of the grantor;
b) A beneficiary of the grantor under descent and distribution statutes of the Commonwealth;
c) An employee of a health care facility in which the grantor is a patient, unless the employee serves as a notary public;
d) An attending physician of the grantor; or
e) Any person directly financially responsible for the grantor's health care.

NOTICE: Execution of this document restricts withholding and withdrawing of some medical procedures. Consult Kentucky Revised Statutes or your attorney.

A person designated as a surrogate pursuant to an advance directive may resign at any time by giving written notice to the grantor; to the immediate successor surrogate, if any; to the attending physician; and to any health care facility which is then waiting for the surrogate to make a health care decision.