

## **LIVING WILL AND PROXY FOR HEALTH CARE DECISIONS**

*Authorized by* The Catholic Bishops of Pennsylvania June 1993

### PREAMBLE

Our Judeo-Christian heritage holds that life is the gift of a loving God. I understand, also as a Catholic, that I may never choose to cause my death. Therefore, I believe that euthanasia and suicide constitute an unwarranted destruction of human life and are not morally permissible.

I understand that I have the right to make decisions about my health care. There may come a time when I am unable to, due to physical or mental incapacity, to express my own health care decisions. In these circumstances, those caring for me will need to turn to someone who knows my values and health care wishes. I am, therefore, signing the attached LIVING WILL, which is my advance directive for health care, to provide the guidance and authority needed to implement my decisions.

### Instructions for Making this Living Will

- 1) Before completing your LIVING WILL, you should discuss instructions you will give with your proxy (if any), your doctor, priest, deacon, family members, or others who may become responsible for your care.
- 2) It is recommended that you periodically review this LIVING WILL with the same people to insure that this directive reflects your wishes.
- 3) If you decide to revoke this LIVING WILL make sure that your doctor and any proxy you appoint will receive notice of the revocation. Revocation can be by any means whether orally to someone, by a written revocation or by destroying the original of this LIVING WILL.

### DECLARATION OF LIVING WILL

I direct that those responsible for my care seek to make health care decisions in accordance with what they know of my stated wishes. I hereby declare and make known my instructions and wishes for my future health care.

The LIVING WILL, which is my advance directive for health care, shall take effect in the event I am determined by the attending physician to lack sufficient capacity to make or communicate decisions about my health care.

The attending physician must also determine that I: have an incurable and irreversible medical condition in an advanced state which will result in death regardless of the continued application of life-sustaining treatment. The determination of my medical condition must be confirmed by a second physician with appropriate expertise.

To inform those responsible for my care of my specific wishes, I direct that the following health care decisions be implemented.

I ask that if I fall terminally ill, I be told of this so that I might prepare myself for death. If I am unable to make decisions for myself, I direct that my spiritual needs be taken care of-that I be attended by a Catholic priest and receive the Sacraments of Reconciliation and the Anointing of the Sick and Viaticum.

I believe that I am not bound in conscience to use ethically extraordinary or disproportionate medical treatments for sustaining life, that is, means that are excessively burdensome or do not offer any reasonable hope of benefit. I direct that, regardless of my physical or mental condition, all ordinary medical care necessary to relieve pain and make me comfortable (which includes medically assisted nutrition and hydration) be provided so long as the procedure for nutrition and hydration does not present a grave, intolerable or unbearable burden and offers a reasonable hope of benefit. I also direct that I not receive ethically extraordinary treatments, unless my proxy appointed herein judges, or, if I did not designate a proxy, then those closest to me judge that at that time there are special and significant reasons why I should receive them.

#### ADDITIONAL PROVISIONS FOR A WOMAN

I direct that if I am pregnant all medically indicated measures and medically assisted nutrition and hydration be provided to sustain my life, regardless of my physical or mental condition, if these measures could sustain the life of my unborn child until birth.

#### DESIGNATION OF A PROXY

Choosing a proxy:  
I hereby designate:

(name) \_\_\_\_\_  
(address) \_\_\_\_\_  
(city) \_\_\_\_\_ (state) \_\_\_\_\_

as my proxy to implement my health care decisions. I direct my proxy to implement my health care decisions as stated in this document. In the event my wishes are not clear, or a situation arises I did not anticipate, my proxy is authorized to make decisions based upon what he or she knows of my wishes.

#### NAME AND ADDRESS OF SUBSTITUTE PROXY (IF PROXY DESIGNATED ABOVE IS UNABLE TO SERVE)

(name) \_\_\_\_\_  
(address) \_\_\_\_\_  
(city) \_\_\_\_\_ (state) \_\_\_\_\_

I have discussed the terms of this designation with my proxy and he or she has willingly agreed to accept the responsibility for acting on my behalf.

I direct that this document become part of my permanent medical records. I understand that I have the right to revoke this Living Will.

#### SIGNATURE AND WITNESSES

**SIGNATURE:** By writing this LIVING WILL, I direct those who may become entrusted with my health care to implement my wishes. I have discussed the terms of this designation with my proxy (if any) and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive. I understand the purpose and effect of this document and sign it knowingly, voluntarily, and after careful deliberation.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
signature \_\_\_\_\_  
address \_\_\_\_\_  
(city) \_\_\_\_\_ (state) \_\_\_\_\_

WITNESSES: I declare that the person who signed this document, or another who was asked to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me, and that he or she knowingly and voluntarily signed this writing by signature or mark in my presence and appears to be of sound mind.

1. witness \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_  
state \_\_\_\_\_  
telephone \_\_\_\_\_  
signature \_\_\_\_\_  
date \_\_\_\_\_

2. witness \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_  
state \_\_\_\_\_  
telephone \_\_\_\_\_  
signature \_\_\_\_\_  
date \_\_\_\_\_

A copy of this LIVING WILL should be given to your physician, appropriate family members, and any proxy you designated.

COPIES: The original or a copy of this document has been given to the following people.

1. witness \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_  
state \_\_\_\_\_  
telephone \_\_\_\_\_

2. witness \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_  
state \_\_\_\_\_  
telephone \_\_\_\_\_

3. witness \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_  
state \_\_\_\_\_  
telephone \_\_\_\_\_

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