

DECLARATION OF LIVING WILL APPOINTMENT

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or my attending advanced practice registered nurse, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I appoint _____, or if he or she is not reasonably available or is unwilling to serve I appoint _____ in the alternative, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to the Montana Rights of the Terminally Ill Act. If the individual(s) I have appointed are not reasonably available or are unwilling to serve, I direct my attending physician or my attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

Signed this ____ day of _____, 20__.

Signature

(Printed Name)

_____, Montana 59
(Address)

The declarant voluntarily signed this document in my presence.

Witness Signature

(Printed Name)

(Address)

Witness Signature

(Printed Name)

(Address)