

# STATE OF LOUISIANA DECLARATION

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_ (month, year).

I, \_\_\_\_\_, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedure would serve only to prolong artificially the dying process, I direct (initial one only):

\_\_\_\_\_ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

\_\_\_\_\_ That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

\_\_\_\_\_ I choose to have Blood/Blood Products withheld or withdrawn (Initial only if applicable.)

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

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

Signed \_\_\_\_\_

City, Parish and State of Residence \_\_\_\_\_

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness \_\_\_\_\_

Witness \_\_\_\_\_

**DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE  
State of Louisiana**

I, \_\_\_\_\_, being of sound mind, do hereby

designate \_\_\_\_\_ to serve as my attorney-in-fact for the purpose of making treatment decisions for me should I be diagnosed and certified as having a terminal and irreversible illness and be incompetent or be in a continual profound comatose state with no reasonable chance of recovery, or otherwise mentally or physically unable to make such decisions myself.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

City and Parish of Residence:

\_\_\_\_\_

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness: \_\_\_\_\_

Witness: \_\_\_\_\_

Sworn and subscribed  
before me, this \_\_\_\_\_ day  
of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public  
My commission is for life.

Notarization of this form is optional.