

DECLARATION OF LIVING WILL

If I should have an incurable or 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 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 to 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)