**DECLARATION OF LIVING WILL**

If I, Principal 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 Date day of Month, Year.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

Address

Line 2: City and State

Phone Number

The declarant voluntarily signed this document in my presence.

Witness Signature Witness Signature

Printed Name Printed Name

Address Address