DECLARATION REGARDING THE WITHHOLDING AND/OR WITHDRAWAL OF LIFE SUSTAINING TREATMENT AND PROCEDURES

I, (*Print Name*) ___________________________ being of sound mind and at least eighteen (18) years of age, do hereby declare as follows:

If I should have an incurable and irreversible condition that has been diagnosed by two physicians and that will result in my death within a relatively short time without the administration of life-sustaining treatment or has produced an irreversible coma or persistent vegetative state, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician pursuant to the Natural Death Act of Guam, to withhold or withdraw such life-sustaining treatment that only prolongs the process of dying or supports irreversible coma or persistent vegetative state and is not necessary for my comfort, nutrition, hydration or to alleviate pain.

Being of sound mind, I have made the following decisions regarding my medical treatment:

( ) I do not want cardiopulmonary resuscitation (CPR)

( ) I do not want to be placed on a kidney machine (dialysis).

( ) I do not to be put on a breathing machine (mechanical ventilation).

( ) I do not want tube feeding for nutrition.

( ) I do not want (specify) ________________________________.

If I have been diagnosed as pregnant, and that diagnosis is known to my physician, this declaration shall have no force or effect during my pregnancy.

Signed this _________ day of ___________________ _________.

PRINT NAME: ____

SIGNATURE: ____

ADDRESS: ____

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The declarant voluntarily signed this declaration in my presence:

I believe that the person who made and signed this Advance Directive is of sound mind and that he/she signed and acknowledged this document in my presence and that he/she is not acting under pressure, duress or undue influence.

I am not entitled to any portion of the estate of the declarant upon his/her death under any will or codicil thereto of the declarant now existing or by operation of law.

I am not a healthcare provider or employee of a healthcare provider, the operator or employee of an operator of a community care facility, or the operator or employee of an operator of a residential care facility for the elderly.

WITNESSES

Print Name: ________________________ Print Name: ________________________

Signature: ________________________ Signature: ________________________

Date: ________________________ Date: ________________________

PATIENT ID LABEL