LIVING WILL

DECLARATION OF A DESIRE FOR A NATURAL DEATH

STATE OF SOUTH CAROLINA **COUNTY OF**

I,_____ (_____ - ____ - _____), Declarant, being at least 18
Social Security Number

years of age and a resident of and domiciled in the City of _____, County of _____,

State of South Carolina, make this Declaration this _____ day of _____, 20_____ .

I willfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of permanent unconsciousness, and I declare:

If at any time I have a condition certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION

INITIAL ONE OF THE FOLLOWING STATEMENTS

If my condition is TERMINAL and could result in death within a reasonably short time,

____ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

OR

____ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

INITIAL ONE OF THE FOLLOWING STATEMENTS

If I am in a PERSISTENT VEGETATIVE STATE or other condition of permanent unconsciousness,

____ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

OR

____ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.

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APPOINTMENT OF AN AGENT (OPTIONAL)

1. You may give another person authority to REVOKE this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

   Name of Agent with Power to Revoke:_____

   Address:_____

   Telephone Number:_____

2. You may give another person authority to ENFORCE this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

   Name of Agent with Power to Enforce:_____

   Address:_____

   Telephone Number:_____

REVOCATION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS; HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN:

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF YOUR INTENT TO REVOKE, BY YOU OR BY SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE ORIGINAL DECLARATIONS REVOKES ALL OF THE ORIGINAL DECLARATIONS;

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE;

(3) BY YOUR ORAL EXPRESSION OF YOUR INTENT TO REVOKE THE DECLARATION. AN ORAL REVOCATION TO THE ATTENDING PHYSICIAN BY A PERSON OTHER THAN YOU IS EFFECTIVE ONLY IF:

(A) THE PERSON WAS PRESENT WHEN THE ORAL REVOCATION WAS MADE;

(B) THE REVOCATION WAS COMMUNICATED TO THE PHYSICIAN WITHIN A REASONABLE TIME;

(C) YOUR PHYSICAL OR MENTAL CONDITION MAKES IT IMPOSSIBLE FOR THE PHYSICIAN TO CONFIRM THROUGH SUBSEQUENT CONVERSATION WITH YOU THAT THE REVOCATION HAS OCCURRED. TO BE EFFECTIVE AS A REVOCATION, THE ORAL EXPRESSION CLEARLY MUST INDICATE YOUR DESIRE THAT THE DECLARATION NOT BE GIVEN EFFECT OR THAT LIFE-SUSTAINING PROCEDURES BE ADMINISTERED;

(4) IF YOU, IN THE SPACE ABOVE, HAVE AUTHORIZED AN AGENT TO REVOKE THE DECLARATION, THE AGENT MAY REVOKE ORALLY OR BY A WRITTEN, SIGNED AND DATED INSTRUMENT. AN AGENT MAY REVOKE ONLY IF YOU ARE INCOMPETENT TO DO SO. AN AGENT MAY REVOKE THE DECLARATION PERMANENTLY OR TEMPORARILY;

(5) BY YOUR EXECUTING ANOTHER DECLARATION AT A LATER TIME.

_____

Signature of Declarant

LIVING WILL

AFFIDAVIT

STATE OF _____ COUNTY OF _____

We, _____ and _____, the undersigned witnesses to the foregoing Declaration, dated this _____ day of _____, 20_____ at least one of us being first duly sworn, declare to the undersigned authority, on the basis of our best information and belief, that the Declaration was on that date signed by the declarant as and for his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence and we, at his request and in his presence, and in the presence of each other, subscribe our names as witnesses on that date. The declarant is personally known to us, and we believe him to be of sound mind. Each of us affirms that he is qualified as a witness* to this Declaration under the provisions of the South Carolina Death with Dignity Act in that he is not related to the declarant by blood, marriage, or adoption either as a spouse, lineal ancestor, descendant of the parents of the declarant, or spouse of any of them; nor directly financially responsible for the declarant's medical care; nor entitled to any portion of the declarant's estate upon his decease, whether under any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the declarant; nor the declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the declarant is a patient. If the declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Lieutenant Governor.

_____ _____

Witness Witness*

Subscribed before me by _____, the declarant, and subscribed and sworn to before me by the witness(es), _____ this _____ day of _____, 20____.

_____

Signature of Notary Public

Notary Public for _____

My commission expires:_____

(SEAL)

*If qualified as a witness, the Notary Public may serve as a witness.