LIVING WILL
DECLARATION
OF

_____

If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, 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, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

Declarant Signature

Signed this _____ day of _____ , 20____

Social Security Number:_____Date of Birth_____

Address:_____ Signature:_____

City/State:_____

The declarant voluntarily signed this writing in my presence.

Signature of witness:_____ Printed name/Date:_____

Signature of witness:_____ Printed name/Date:_____

-OR-
NOTARY

The declarant voluntarily signed this document in my presence.

STATE OF NEBRASKA)
)ss.
COUNTY OF _____)

Notary Public