Advance Medical Directive
[Living Will]

TO WHOM SO EVER IT MAY CONCERN
& To all the Concerned Doctors / Hospitals

I, Mr. / Mrs. ______________________, age ____yrs. residing at ____, Pune today on________ have to state as under:

At present, I am in perfect mental state to make this Advanced Directive.
My immediate family consists of:

My Son, _______________________________(name/age)
My Daughter, __________________________(name/age)
My Wife, ___________________________(name/age)

I authorize anyone of my above family members to take decision as to my living will made here in under:

I hereby state that in case, I am hospitalized due to any critical disease or am critically injured in any accident, and am not in conscious state to decide anything regarding line of my medical management, then-

i. I should not be kept on any life support machines (like ventilator, dialysis etc.).
ii. I should not be resuscitated.
iii. Also I should not be kept isolated from my family and kept in any recovery room, for more than one day.
iv. I want to be only kept as comfortable as possible, with medication only and let go in peace.

I have lived my life well and have no desires or regrets and only want to die peacefully& with dignity, with no contraption attached on my body.

v. I also wish, that after my death, if possible, my eyes may be removed, for the purpose of transplantation, to give vision to anyone who is in need of it.

vi. I hereby authorize/do not authorize my family members mentioned above to take active steps for organ donations

vii. I hereby authorize/do not authorize my family members mentioned above to donate my body/remains for medical purposes.

I have informed my family members that I have made this Living Will Voluntary.

In witness whereof, I have signed this, my Living Will, on this _________ day of __________ in the year ____, at ____, in the presence of following witness.

____

Signature

We both have appended our signatures to this Living will
of ___________________, at his/her request and in his/her presence.

1. Sign : __________________
Name : _________________
Designation : ________________
Address : __________________
Mobile No. : _________________

2. Sign : __________________
Name : _________________
Designation : ________________
Address : __________________
Mobile No. : _________________

OPTIONAL(but preferred)Dr's certificate:

I, Dr. ________________________, having interviewed and examined Mr/Mrs ____ today, on _____________, certify that Mr./Mrs. _________________ _______________ is mentally fit and fully aware about the contents of this living will (Advance Directive).

Doctors Signature: ______________________

Doctors Name: ______________________

Registration No.: ____________________

SEAL