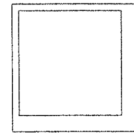
DECLARATION

By ______________________________

RELATING TO USE OF LIFE SUSTAINING TREATMENT

If I should 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 NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement, you must INITIAL the statement in the box provided:



Withholding or withdrawal of artificial nutrition and hydration may result in my death by starvation or dehydration. **Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld pursuant to this declaration.**

SIGN THIS DOCUMENT IN FRONT OF AT LEAST TWO WITNESSES WHO WILL SIGN BELOW YOUR SIGNATURE.

Signed this ______ day of _________________, 20____.

Declarant Signature: ____________________________________

Address:____

We, the following witnesses, declare that the declarant voluntarily signed this Declaration Relating to Use of Life Sustaining Treatment in our presence.

Witness Signature: ______________________________________

Address:____

Witness Signature: ______________________________________

Address:____