LIVING WILL (Instructions for treatment in the dying process according Hans Henning Atrott, former Director of Board of the World-Federation of Right-to-Die-Societies)

Name___________________________________

First name______________________________

Address______________________________________

Date of birth_______**Tel.**_________________**Fax**_______________

E-mail___________________________

I wish to be assured that I shall not be allowed to vegetate degradingly and suffer harrowing pain during the final stage of my life. Of my own free will and being in full mental and spiritual control and being full aware of the significance and consequence of my decision, after careful consideration I hereby declare the following:

DIRECTIVES

KNOWLEDGE OF MY CONDITION

In the event of a prognosis of two physicians indicating that I am suffering from a terminal condition or illness, I wish to have this explained to me in full, even if this should result in the deterioration of my psychological condition

Yes_______________________________**No**_______________________________

(Delete non applicable)

GUIDING PRINCIPLES FOR THE THERAPY IN THE PROCESS OF DYING

In the event of my being unable to express my will myself, I hereby direct the following in advance: **1. Passive Euthanasia**

I assume it to be a matter of course that any pain I may experience will always be eliminated or alleviated if

- a terminal and irreversible process has set in; or
- that there is only a minor chance of my regaining consciousness; or
- that is highly likely that I will suffer severe, permanent brain damage which will no linger permit me to have a personal existence; or
- that only a very risky operation can help. I understand a very risky operation to be one as a result of which the probability of my dying is assessed as being at least 80%.

2. Indirect Euthanasia

I assume it to be a matter of course hat any pain I may experience will always be eliminated or alleviated. In the event of two doctors having diagnosed me to be in al terminal condition, I hereby demand that I be granted pain-killing medication in adequate amounts, even if this means that death will occur earlier.

These guidelines shall also provide the basis and criteria for the durable power of attorney (proxy) or any person who takes care of me if I should be unable to care for myself.

PROXY

In the event of my being partially or completely incapable of taking care of my affairs as a result of my age and/or my state of health I hereby grant the following

Authorization (proxy) to make declarations in respect of treatment appointing

Mr./Mrs *(*First name- and surname*)*________________________

Date of birth______________________

Address___________________________________Phone / Fax*:*_____________

E-mail*:*_________

as my **proxy** and herewith authorize him/her to make all the necessary declarations in respect of my treatment on my behalf. This person is therefore always to be competently informed of my condition.
My proxy shall be entitled to grant power of representation, i.e. to appoint another proxy to act on his behalf.
In the event of plans to take measures contrary to my instructions I hereby demand that my proxy is contacted and informed immediately. Said person is authorized to make decisions on my behalf and to thus enforce my will. The declarations of this person are binding. There is no scope for medical conjectures about my wishes.

DURABLE POWER OF ATTORNEY

In case of an appointment of a durable power of attorney to act on my behalf if I should be unable to care for myself I hereby propose the above named proxy for that.
(Delete this chapter if you do not want so

DISTRIBUTION

I have submitted my living will to:
The local Court
in:____

My proxy/durable power of attorney
(address/phone/email____

My family doctor
(address/phone/email____

Further deposits:____

IN CASE OF DISREGARD

In the event of suspicion of contravention of my living will my relatives or my proxy are authorized to tale steps as they see fit in accordance with the provisions of criminal or civil law. This authorization, which shall remain valid after my death, also includes the authorization to examine my medical record. In the event of suspicion of contravention of my living will, I hereby free doctors and nursing staff from their obligation to observe secrecy. Bill for treatments against my hereby declared will shall not be paid.

Place, date, signature of the declaring____

Place, date, signature of a witness_____________________________________

Place, date signature of a second witness____