LIVING WILL
ADVANCE HEALTH CARE DIRECTIVE

(South Carolina - §44-77-40)

In the event that the time comes and I am incapacitated to the point that I am no longer able to actively take part in decisions for my own life, and I am unable to direct my healthcare physician as to my own medical care, I hereby authorize this Living Will as my Advance Health Care Directive to stand as a testament of my wishes.

I, Ms Kimely, residing at 56789 Broad St, Columbia in the County of USin the State of South Carolina in the zip code 2222 and whose telephone number is 888-888-8888, being of sound mind, and acting willingly and without duress, fraud or undue influence, hereby direct that the instructions provided herein are to be recognized as a formal statement of my desires with regards to my health care, custody and medical treatment, and as such I hereby voluntarily declare and make this designation with regards to my Living Will (aka Advance Health Care Directive and/or Health Care Proxy). These instructions and directives shall be binding upon all involved to the fullest extent allowable by law.

DESIGNATION OF HEALTH CARE ADVOCATE

I hereby designate Joyce, residing at 1234567 Broad St, Columbia , Florida 2222 and whose telephone number is 888-888-8888, as my advocate and agent to make any and all health care decisions on my behalf should I ever be diagnosed with a terminal illness, disease, injury or other condition which prevents me from making those decisions, or should I become incapacitated or permanently unconscious (in a coma or persistent vegetative condition) where I would remain permanently unable to make decisions.
In the event that I find it necessary to revoke the original above named advocate's authority, or should s/he be unwilling or unable to make the necessary health care decisions on my behalf, I then designate Stanleyyy, residing at 901234 Hyde St, US, South Carolina 2222 and whose telephone number is 888-888-8888, to serve as my first alternate health care advocate or agent.

ADVOCATE'S AUTHORITY COMMENCEMENT

My advocate's or agent's authority shall become effective upon my primary or attending physician's determination that I lack the capacity to make my own health care decisions, or as otherwise stated herein:

- Authority shall commence upon the occurrence of the following condition: If I am unable to feed myself or if in a coma and non responsive. Also, brain damage or must stay alive through a machine. I do not want to live under these conditions.

ADVOCATE'S GENERAL POWERS

My health care advocate or agent shall have the power to make health care, custody and medical treatment decisions on my behalf if my attending and/or primary physician makes the determination that I am unable to make those decisions.

I have specific directives regarding the delivery of medical care in certain health care conditions. Therefore, I wish to direct my medical treatment by way of the following conditions:

- In the event that I should be diagnosed with a terminal illness, disease or injury, I wish to RECEIVE life-sustaining medical treatment to attempt to prolong my life.

- In the event I should fall into a permanently unconscious state (coma or persistent vegetative condition), I wish to NOT RECEIVE life-sustaining medical treatment in an attempt to prolong my life.

- In the event that I am diagnosed as being in an untreatable condition or in severe pain, where no type of surgical or other relief can be obtained, I wish to NOT RECEIVElife-sustaining medical care in an effort to try and prolong my life.

LIFE-SUSTAINING MEDICAL TREATMENT

Should any of the aforementioned events occur, I wish to leave the following directives regarding the treatment and procedures which may be used, withheld or withdrawn:

- I wish to RECEIVE cardiac resuscitation (CPR) in an attempt to try and prolong my life.

- I wish to RECEIVE life-support (e.g., respirators, ventilators) used in an effort to replace or support my natural breathing.

- I wish to NOT RECEIVEtube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

- I wish to RECEIVE blood or blood products.

- I wish to RECEIVE any form of surgery or invasive diagnostic tests.

- I wish to RECEIVE kidney dialysis.

- I wish to RECEIVE antibiotics or medication in an attempt to try and prolong my life.

I understand that if I do not specifically indicate my preferences above regarding any of the forms of treatment, I may be subjected to that form of treatment.

COMFORT AND PAIN RELIEF

With regards to the aforementioned medical situations, I hereby provide the following directives pertaining to the comfort care and pain relief:

- I wish to RECEIVE maximum pain relief medication.

- I wish to RECEIVE maximum pain relief medication if it may unintentionally hasten my death.

- I wish to RECEIVE maximum pain relief medication if it may result in temporary addiction should I survive, recover or rebound from my current conditions and/or extended hospital stay.

OTHER DIRECTIVES

In addition to the outlined directives above, I wish to provide the following additional directives:

Only sustain life with these condition through my primary and secondary appointed person

ADVOCATE'S OBLIGATION

My appointed advocate or agent shall make health care decisions on my behalf in accordance with the attached Health Care Power of Attorney and my wishes known to my advocate and/or agent. To the extent that my wishes are not known to my advocate or agent, my advocate or agent shall make the necessary health care decisions for me in accordance to what my advocate deems to be in my best interest. In determining those best interests, my advocate shall take into consideration my personal values to the extent known to the advocate.

GUARDIAN NOMINATION

In the event that a guardian needs to be appointed to act in my best interests, I nominate the advocate or agent already named herein in the order designated to act as my guardian.

END OF LIFE DECISIONS

I direct my health care advocate, health care provider and others who may be involved in my health care, to withhold or withdraw treatment in accordance with the choice I have indicated below:

Choice Not To Prolong Life

It is my choice for my life not to be prolonged if:

- I have an incurable and irreversible condition that will result in my death within a relatively short amount of time
- I become unconscious and, to a reasonable degree of medical certainty, remain in a permanent vegetative state
- The likely risks and burdens outweigh the expected benefits of prolonging life.

ANATOMICAL GIFT - DONATION

Upon my death, it is my wish and desire that:

- I donate my body

The above donated organs, tissues and/or parts can be used for the following purposes:

- Any purpose authorized or allowable by law

PREGNANCY STIPULATIONS

Under some state laws, advance directive instructions to refuse treatment may not be honored while a woman is pregnant. If you wish your advance directives to apply during pregnancy, you will improve your chances of having this wish honored, although not ensure it, by stating the wish clearly.

In the event that it is determined that I am pregnant and that diagnosis is known to my primary or attending physician or advanced health care advocate, this document shall have no force or effect during the course of my pregnancy. However, if at any point it is determined that it is not possible that the fetus is viable or could develop to the point of live birth with continued application of life-sustaining efforts and/or procedures, it is my preference that this document be given full effect and force at that point. In the event that life-sustaining procedures could be physically harmful or unreasonably painful to me in a manner that cannot be alleviated by the use of pain relieving medication, I request that my desire for personal physical comfort be given consideration in determining whether this document shall be effective if I am pregnant.

PRIMARY PHYSICIAN APPOINTMENT

I herein designate Sandra Kmp , located at 123456 Lee St, Columbia, South Carolina 2222 and whose telephone number is 888-888-8888, as my primary health care physician to provide and/or supervise all my health care needs should I ever be diagnosed with a terminal illness, disease, injury, or should I become incapacitated or permanently unconscious (in a coma or persistent vegetative condition) where I would remain permanently unable to make decisions.

In the event that I find it necessary to revoke the above named primary physician, or should s/he be unwilling or unable to provide the necessary medical and health care on my behalf, I then designate Sykes LM , located at 1234 Leesburg Rd, Columbia, 2222 and whose telephone number is 888-888-8888, to serve as my alternate health care provider.

DECLARANT STATEMENT AND SIGNATURE

This instrument shall be governed by the laws of South Carolina, and I respectfully request that it be honored in any state in which I may reside at the time that this Living Will shall take effect.

By signing below, I certify that I am fully aware and completely understand the contents of this document, and that I am of sound body and mind. Furthermore, I am of the legal age of consent and not under undue influence, fraud or duress.

WITNESSES

This Living Will (aka Advance Health Care Directive and/or Health Care Proxy) must be signed by two adult witnesses that are personally present when I sign this document.

WITNESS STATEMENT

I certify that I am 18 years of age or older and that I know the Declarant personally or have been provided with valid proof as to his/her identity and believe him/her to be of sound mind and under no duress, fraud or undue influence. The Declarant has had the opportunity to read this document and has signed or acknowledged his/her signature or mark in my presence.

Under penalty of perjury I declare that I am not related to the Declarant by blood, marriage or adoption, nor am I responsible for his/her medical care or costs. Furthermore, I am not the primary or attending physician or an employee of the physician or other health care provider or current care facility for the Declarant. I also attest that I am not an employee of any life or health insurance provider, nor am I involved with the direct physical care of the Declarant. Further, I have no claim to the Declarant's estate, and to the best of my knowledge, I am not entitled to any part of the Declarant's estate upon his/her death with any Will now in existence or by any other process of law.

(Declarant Signature) (Date)

(First Witness Signature) (Date)
Sonny
12345 Lee St
Columbia, South Carolina
2222
888-888-8888

(Second Witness Signature) (Date)
Tronn
12345 Lee St
Columbia, South Carolina
2222
888-888-8888

NOTARY PUBLIC
CERTIFICATE OF ACKNOWLEDGMENT

STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND)

On this date, , the Declarant, Ms Kimely, personally appeared before me and having provided verifiable identification to be the Declarant whose name is subscribed to this instrument and acknowledged to me that s/he executed the same in his/her capacity, and that by his/her signature on the instrument, executed the instrument.

I declare that s/he appears to be of sound mind and not under or subject to duress, fraud or undue influence, that s/he acknowledges the execution the same to be his/her voluntary act and deed, and that I am not the advocate, attorney-in-fact, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by any other means or process of law.

I also declare that I have been provided with verifiable identification for the above-mentioned witnesses whose names are subscribed to in this instrument, and hereby acknowledge their signatures as well.

WITNESS my hand and seal.

_____
(Notary Signature)

My Commission Expires: _____
(Date)