# Advance Medical Directives - Declaration

This Declaration on My Life is made by me
(Full Name of the Person): _____
(Date of Birth): _____, ID Document and Number:_____
Resident of (full address): _____On (date) _____at place _____.

I am an adult, aged ___years, of sound mind. I am making this 'declaration' of my own free will, voluntarily, without any undue influence or constraint, coercion, inducement or compulsion and after having full knowledge or information and being aware that in the event I can do longer take part in decision-making regarding my medical treatment, this 'declaration' will comprise the final expression of my wishes. It is requested that all concerned take these wishes into account before making any medical decision regarding my life.
If, at any time,

1. I became terminally ill, and if I am undergoing prolonged medical treatment with no hope of recovery and cure of the ailment and do not have decision-making capacity,
2. I have a disease state of prolonged medical treatment with no hope of recovery and or cure of the ailment and do not have any decision-making capacity.
3. I reach persistent vegetative state with no reasonable expectation of regaining significant cognitive functioning and with no hope of recovery.

In aforesaid events and circumstances, I declare that my medical treatment may be withdrawn, or no specific medical treatment should be given, which will only have the effect of delaying the process of my death that may otherwise cause me pain, anguish and suffering and further put me in a state of indignity.
Other wishes: (please write by hand)
I request that my family member and treating doctors honour this 'declaration' as the final expression of my right to refuse medical treatment, and I hereby accept all the consequence of such refusal.

In the event I became incapable of taking the decision at the relevant time, I authorize the Shri/Smt. _____, s/o or d/o of w/o. Shri/Smt. _____, aged _____ years, having Aadhar no. _____, Mob No. _____, Email _____ and resident of _____who is my _____, to give consent to refuse or withdraw medical treatment in a manner consistent with the Advance Directive from time to time on my behalf.

I say that no person shall be held responsible for taking necessary actions in terms of these directives.

I declare that I have understood the consequences of executing this document and further that this "declaration/instructions/authority" shall remain in force during my lifetime unless I revoke it at any time in future.

SIGNATURE

WITNESSES:

| | |
|---|---|
| Name: | Address: |
| Sign: | |
| Name: | Address: |
| Sign: | |

EXECUTED BEFORE ME
Notary or Gazette Officer

Place: Date:

Presented by:- Citizens for Dignity in Death Association - 400088

CDD-4