

Free Living Will Form

Personal Information

- Full Name: _____
- Address: _____
- City: _____
- State: _____
- Zip Code: _____
- Phone Number: _____
- Email Address: _____
- Date of Birth: _____

Health Care Proxy

- Primary Agent Name: _____
- Primary Agent Address: _____
- Primary Agent Phone Number: _____
- Secondary Agent Name: _____
- Secondary Agent Address: _____
- Secondary Agent Phone Number: _____

Medical Treatment Choices

Medical Treatment Type	Consent	Refusal	Additional Notes
Cardiopulmonary Resuscitation (CPR)	<input type="checkbox"/>	<input type="checkbox"/>	
Mechanical Ventilation	<input type="checkbox"/>	<input type="checkbox"/>	

Artificial Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	
Pain Management	<input type="checkbox"/>	<input type="checkbox"/>	
Organ Donation	<input type="checkbox"/>	<input type="checkbox"/>	

Further Instructions

- **Specific Instructions:** _____
- **Personal Preferences:** _____

Signature

- **Signature:** _____
- **Date:** _____

Witnesses

- **Witness 1 Full Name:** _____
- **Witness 1 Signature:** _____
- **Witness 1 Date:** _____
- **Witness 2 Full Name:** _____
- **Witness 2 Signature:** _____
- **Witness 2 Date:** _____