

# LIVING WILL DECLARATION

TO MY FAMILY, PHYSICIAN AND MEDICAL FACILITY:

I, Norma Louise Robbins, of Yorktown, Delaware County, Indiana, being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease or illness; (2) my death will occur within a short period of time; and (3) the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort and care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration):

\_\_\_\_\_ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

*N.L.R.* \_\_\_\_\_ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

\_\_\_\_\_ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

Without affecting or limiting the generality of the foregoing, I specifically do not wish to have administered to me in the event of a terminal condition treatments such as surgeries, dialysis, chemotherapies, or radiations, and I further do not want electrical or mechanical resuscitation of my heart when it has stopped beating, nasogastric tube feedings when I am paralyzed and unable to swallow and mechanical respiration when my brain can no longer sustain my own breathing.

If it does not jeopardize the chance of my recovery to a meaningful, sentient life or impose an undue burden on my family, I would like to spend my last days at home rather than in a health care facility.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that

this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal as I have. I direct such persons to base their decision as to my medical treatment on my wishes as expressed herein and to treat this document as valid and in full force and effect.

I authorize the delivery of this declaration to any physician and health care facility that may render medical treatment to me and I authorize any physician having custody of this document to release any needed medical information and to deliver any documents and information to any person as may be necessary or desirable to accomplish my intent as expressed herein.

I understand the full import of this declaration and I am executing this document as statement of my intent this 3rd day of July, 1996.

Signature Norma Louise Robbins  
Norma Louise Robbins

Address: 8400 W. CR 400 S.  
Yorktown, Indiana 47396

On the 3rd day of July, 1996, the declarant signified to me that this Living Will Declaration was being made by the declarant freely and voluntarily and, in my presence the declarant signed such declaration, or it was signed by another person in the declarant's presence and at the declarant's express direction, and I, at the declarant's request, and in the declarant's presence and in the presence of the other witness hereto, signed my name in witness thereof. I further state that the declarant has been personally known to me, and is believed by me to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant, am not, to the best of my knowledge, entitled to any part of the declarant's estate and am not directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years old.

WITNESS Peggy J. Lunsford Peggy J. Lunsford  
Written Name Printed Name

WITNESS Debra K. Streat Debra L. Streat  
Written Name Printed Name

This declaration was prepared by: Andrew R. Retherford, Attorney at Law, UAW-GM Legal Services Plan, 1100 Martin Luther King, Jr., Blvd., Muncie, Indiana 47304. Phone: (317) 288-8980.