

LIVING WILL AND ADVANCE HEALTHCARE DIRECTIVE

This document records my medical treatment preferences and final wishes and is intended for use by hospitals, doctors, and healthcare providers. It does not replace my legal will and is a separate document.

Full name: _____

Identity number: _____

Date of birth: _____

Contact person: _____

Contact number: _____

When this living will applies:

This living will applies if I am unable to communicate or make decisions for myself and a medical practitioner confirms that I have **no reasonable** prospect of recovery due to terminal illness, permanent unconsciousness, or an irreversible medical condition.

Treatment preferences

I do not consent to medical treatment that serves only to prolong my life artificially, including CPR, mechanical ventilation, artificial feeding and hydration, dialysis, or advanced life support.

I request full comfort care, pain relief, dignity-focused care, and palliative support at all times, even if such treatment may unintentionally shorten my life.

If any spiritual, religious or cultural considerations apply to my medical care or treatment decisions, they are as follows:

After my death

If reasonably possible, I request that the following wishes be respected after my death.

Organ and tissue donation (if applicable)

- ☐ I consent to organ and tissue donation
- ☐ I do not consent to organ and tissue donation

Body disposition

- ☐ Donation of my body to medical science (cremated ashes returned after 2 years)
- ☐ Burial
- ☐ Cremation:

Ashes scattered preferred location: _____

INITIALS: _____

CONT//

Final wishes after death

If reasonably possible, I request that the following wishes be respected after my death:

Funeral or memorial service:

- | | | |
|--|--|--|
| ☐ Private (Family only) | ☐ Religious | ☐ Celebration of Life |
| ☐ Traditional | ☐ Non-religious | ☐ No service |

I understand that these final wishes may not be legally binding, but I request that my family and executor honour them as far as reasonably possible.

My complete and valid legal will is held with: _____

Contact details: _____

Declaration

I confirm that I am making this living will voluntarily, that I understand its contents, and that it reflects my wishes. This declaration is signed and dated by me in the presence of the two witnesses below

Signed: _____ Date: _____

NOTE: Witnesses should not be family members or your personal medical practitioner(s), nor should they be beneficiaries in your Last Will and Testament.

WITNESS ONE Full Name: _____

Identity number/passport no.: _____

Signed: _____ Date: _____

WITNESS TWO Full Name: _____

Identity number/passport no.: _____

Signed: _____ Date: _____