DECLARATION

(direct physician or attending advanced practice registered nurse to withhold life-sustaining treatment)
MCA 50-9-103

If I, _________________________ should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician or my attending advanced practice registered nurse, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician or my attending advanced practice registered nurse, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Signed this_______day _______________ of ______________.

____
Address

Phone #

The declarant voluntarily signed this document in my presence.

____
Witness Signature

____
Printed Name

____
Address

____
Witness Signature

____
Printed Name

____
Address

"These forms were downloaded from the Department of Public Health and Human Services website and have been completed Pro Se."