



DIVISION OF PUBLIC HEALTH

Scott Walker
Governor

1 WEST WILSON STREET
P O BOX 2659
MADISON WI 53701-2659

Dennis G. Smith
Secretary

State of Wisconsin

Department of Health Services

608-266-1251
FAX: 608-267-2832
TTY: 888-701-1253
dhs.wisconsin.gov

To Whom It May Concern:

Enclosed is the Declaration to Physicians (Living Will) form you requested. This form makes it possible for adults in Wisconsin to state their preferences for life-sustaining procedures and feeding tubes in the event the person is in a terminal condition or persistent vegetative state.

Be sure to read both sides of the form carefully and understand it before you complete and sign it.

The withholding or withdrawal of any medication, life-sustaining procedure or feeding tube may not be made if the attending physician advises that doing so will cause pain or reduce comfort, and the pain or discomfort cannot be alleviated through pain relief measures.

Two witnesses are required. Witnesses must be at least 18 years of age, not related to you by blood, marriage or adoption, and not directly financially responsible for your health care. Witnesses may not be persons who know they are entitled to or have a claim on any portion of your estate. A witness cannot be a health care provider who is serving you at the time the document is signed, an employee of the health care provider, other than a chaplain or a social worker, or an employee other than a chaplain or social worker of an inpatient health care facility in which you are a patient. Valid witnesses acting in good faith are immune from civil or criminal liability.

You should make relatives and friends aware that you have signed the document and the location where it is kept. A signed form may be kept in a safe, easily accessible place until needed. The document may be filed for safekeeping for a fee with the Register in Probate of your county of residence, but it is not required that it be filed. The fee for filing with the Register in Probate has been set by State Statute at \$8.00.

You are responsible for notifying your attending physician of the existence of the Declaration. An attending physician who is notified shall make the Declaration part of your medical records. A Declaration that is in its original form or is a legible photocopy or electronic facsimile copy is presumed to be valid.

If you have both a Declaration to Physicians and a Power of Attorney for Health Care, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Physicians.

Up to four copies of the Declaration to Physicians are available free to anyone who sends a stamped, self-addressed, business-size envelope to: Living Will, Division of Public Health, P.O. Box 2659, Madison, Wisconsin 53701-2659. You may make additional copies of the enclosed blank form. The form is also available on the Department of Health Services Web page <http://dhs.wisconsin.gov/forms/DPHnum.asp>.

If you have questions about the availability of the Declaration to Physicians (Living Will) form or obtaining larger quantities of the form, you may contact the Division of Public Health at (608) 266-1251.

INSTRUCTIONS FOR DECLARATION TO PHYSICIANS FORM

Definitions

“Declaration” means a written, witnessed document voluntarily executed by the declarant under State Statute 154.03 (1), but is not limited in form or substance to that provided in State Statute 154.03 (2).

“Department” means the Department of Health Services.

“Feeding tube” means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of a qualified patient.

“Terminal condition” means an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.

“Persistent vegetative state” means a condition that reasonable, medical judgment finds constitutes complete and irreversible loss of all the functions of the cerebral cortex and results in a complete, chronic and irreversible cessation of all cognitive functioning and consciousness and a complete lack of behavioral responses that indicate cognitive functioning, although autonomic functions continue.

“Qualified patient” means a declarant who has been diagnosed and certified in writing to be afflicted with a terminal condition or to be in a persistent vegetative state by two physicians, one of whom is the attending physician, who have personally examined the declarant.

“Attending physician” means a physician licensed under State Statute Chapter 448 who has primary responsibility for the treatment and care of the patient.

“Health care professional” means a person licensed, certified or registered under State Statutes Chapters 441, 448 or 455.

“Inpatient health care facility” has the meaning provided under State Statute 50.135 (1) and includes community-based residential facilities as defined in State Statute 50.01 (1g).

“Life-sustaining procedure” means any medical procedure or intervention that, in the judgment of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient.

“Life-sustaining procedure” includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis and other similar procedures, but does not include (a) the alleviation of pain by administering medication or by performing an medical procedure; or (b) the provision of nutrition or hydration.

Procedures for signing Declarations

A Declaration must be signed by the declarant in the presence of two witnesses. If the declarant is physically unable to sign a Declaration, the Declaration must be signed in the declarant’s name by one of the witnesses or some other person at the declarant’s express direction and in his or her presence; such a proxy signing shall either take place or be acknowledged by the declarant in the presence of two witnesses.

Effect of Declaration

The desires of a qualified patient who is competent supersede the effect of the Declaration at all times. If a qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures or feeding tubes, a Declaration executed under this chapter is presumed to be valid.

Revocation of Declaration

A Declaration may be revoked at any time by the declarant by any of the following methods:

- 1) By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the declarant or by some person who is directed by the declarant and who acts in the presence of the declarant.
- 2) By a written revocation, signed and dated by the declarant expressing the intent to revoke.
- 3) By a verbal expression by the declarant of his or her intent to revoke the Declaration, but only if the declarant or a person acting on behalf of the declarant notifies the attending physician of the revocation.
- 4) By executing a subsequent Declaration.

The attending physician shall record in the declarant’s medical records the time, date and place of the revocation and time, date and place, if different, that he or she was notified of the revocation.

Liabilities

No physician, inpatient health care facility or health care professional acting under direction of a physician may be held criminally or civilly liable, or charged with unprofessional conduct of any of the following:

- 1) Participating in the withholding or withdrawal of life-sustaining procedures or feeding tubes under Chapter 154, subchapter II.
- 2) Failing to act upon a revocation unless the person or facility has actual knowledge of the revocation.
- 3) Failing to comply with a Declaration, except that failure by a physician to comply with a Declaration of a qualified patient constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the patient to another physician who will comply with the Declaration.

**PLEASE BE SURE YOU READ THE FORM CAREFULLY AND UNDERSTAND IT
BEFORE YOU COMPLETE AND SIGN IT**

**DECLARATION TO PHYSICIANS
(WISCONSIN LIVING WILL)**

I, _____
being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

1. If I have a **TERMINAL CONDITION**, as determined by 2 physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes:

- YES, I want feeding tubes used if I have a terminal condition.
- NO, I do not want feeding tubes used if I have a terminal condition.

If you have not checked either box, feeding tubes will be used.

2. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures:

- YES, I want life-sustaining procedures used if I am in a persistent vegetative state .
- NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

If you have not checked either box, life-sustaining procedures will be used.

3. If I am in a **PERSISTENT VEGETATIVE STATE**, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of feeding tubes:

- YES, I want feeding tubes used if I am in a persistent vegetative state.
- NO, I do not want feeding tubes used if I am in a persistent vegetative state.

If you have not checked either box, feeding tubes will be used.

If you are interested in more information about the significant terms used in this document, see section 154.01 of the Wisconsin Statutes or the information accompanying this document.

ATTENTION: You and the 2 witnesses must sign the document at the same time.

Signed _____ **Date** _____

Address _____ **Date of Birth** _____

I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Witness Signature _____ **Date Signed** _____

Print Name _____

Witness Signature _____ **Date Signed** _____

Print Name _____

DIRECTIVES TO ATTENDING PHYSICIAN

1. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when 2 physicians, one of whom is the attending physician, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

2. The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless you believe that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed.

3. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

4. If you know that the patient is pregnant, this document has no effect during her pregnancy.

* * * * *

The person making this living will may use the following space to record the names of those individuals and health care providers to whom he or she has given copies of this document:

