WILL FOR MEDICAL DECISION (ADVANCE MEDICAL DIRECTIVE / LIVING WILL)

This is the LAST WILL and TESTAMENT executed on this ____ day of _____ 20___ (Two Thousand and _____) by me, Sri/Smt. _____, Aged about ____ years, Son/Daughter/Wife of _____, _____ by caste, _____ by profession, permanent resident of Village/Locality _____, P.O.- _____, P.S.- _____, District - _____, at present residing at _____, Aadhar No. _____, Mobile No. _____. I execute this Will out of my own free will, in a sound disposing state of mind and without any pressure, influence or coercion. I declare this to be my Last Will and an Advance Medical Directive / Living Will expressing my medical treatment decisions.

That I am aware that in certain medical situations I may be unable to communicate or make decisions regarding my health. Therefore, I clearly record my choices regarding medical treatment, life-support measures, and end-of-life care.

That I appoint the following person as my Medical Decision Maker / Healthcare Proxy after my death or during a medical emergency where I cannot express my decisions:
Sri/Smt. _____, aged ____ years,
Son/Daughter/Wife of _____,
Permanent resident of _____,
at present residing at _____, Profession: _____.
He/She shall act as the sole executor/executrix for implementing this medical directive.

That my medical decisions are as follows:

- Life-support & Life-prolonging Treatment – If I suffer from a terminal illness, irreversible brain damage, or permanent unconsciousness with no reasonable chance of recovery, I direct that no artificial life support, ventilator, or invasive life-prolonging treatment be continued solely to prolong biological life. However, I desire humane care, including pain relief and dignity-based treatment.
- Artificial Nutrition & Hydration – I direct that artificial feeding tubes or forced hydration be withheld/withdrawn if they only prolong suffering and offer no recovery.
- Resuscitation (CPR / Advanced Life Support) – If recovery chances are negligible, I direct that no CPR or aggressive resuscitation be administered.
- Organ Donation (optional) – I express my wish to donate my organs after death / I choose not to donate my organs.

- Refusal of Certain Treatments – I do not wish to undergo any treatment that causes extreme burden, suffering, or indignity without meaningful medical benefit.
- Comfort Care – I direct doctors to provide palliative care, pain relief and comfort measures even if such medication may indirectly shorten life.

That this Medical Will expresses my clear, conscious and voluntary medical preferences and shall guide all medical professionals and family members.

That the above-named proxy/guardian shall have full authority to interpret and execute my medical decisions as per this Will.

That I reserve the full right to modify, alter or cancel this Medical Directive during my lifetime.

That until I am alive and conscious, I retain the full right to make all medical decisions personally.

SCHEDULE OF MEDICAL DIRECTIVES

- Conditions where life support should not be continued:
  _____
- Conditions for refusal of resuscitation:
  _____
- Organ donation instructions:
  _____
- Healthcare proxy's powers:
  _____

Signed by _____, the TESTATOR, acknowledging this to be his/her Last Will and Advance Medical Directive, in the presence of the two witnesses. The contents were read over and explained in vernacular language, and the Testator signed/affixed a thumb impression in our presence.

Date: _____
Place: _____

TESTATOR
Signature: _____

WITNESSES:

Signature: _____
Name: _____
Son of: _____
Address: _____

Signature: ___________________________
Name: _______________________________
Son of: ______________________________
Address: _____________________________