Disclaimer

This document is provided solely as a sample format of an **Advance Medical Directive (AMD),** commonly referred to as a Living Will. It is intended for general information and illustrative purposes only and does not constitute legal, medical or professional advice of any kind.

ADVANCE MEDICAL DIRECTIVE FORM

Full Name: _____

Date of Birth: _____ Age: _____

Gender: _____ ID Number: _____

Residential Address:

_____

Local Municipal Office/Panchayat: _____

Contact Number: _____ Email: _____

I, [Full Name], being of sound mind and in full control of my faculties, voluntarily execute this Advance Medical Directive (AMD) to express my healthcare preferences in the event that I become incapable of making medical decisions. I write this document to instruct my family, any medical professional and person, organization or authority who has any control over my future care. This decision/directive replaces any previous AMDs I have made.

I affirm that this directive is made freely, without coercion, undue influence, or inducement, and that I fully understand its implications.

This directive shall take effect only if and when I have lost the capacity to make or communicate medical decisions due to any of the following conditions:

- A terminal illness with no reasonable chance of recovery.
- A permanent unconscious/vegetative state with no expectation of regaining awareness.
- A progressive illness that irreversibly impairs my cognitive and physical functions,

not when I simply need time or help to communicate.

I direct that the following medical interventions shall not be administered if they serve only to prolong my life without the possibility of recovery:

☐ Artificial ventilation

☐ Cardiopulmonary resuscitation (CPR)

☐ Defibrillation

☐ Dialysis

☐ Any other extraordinary life-sustaining measures

☐ ECMO

☐ I request that I receive necessary medical care to relieve pain, discomfort, and suffering, even if such treatment may have secondary effects such as respiratory suppression or sedation.

☐ I decline all artificial life-sustaining measures intended to keep me alive if my condition is irreversible and such measures are intended solely to prolong my life, unless necessary for my comfort.

I authorize the donation of my organs and tissues for:

☐ Transplantation

☐ Medical Research

☐ Medical Education

☐ I do not wish to donate my organs and tissues.

I appoint the following individual as my Healthcare Representative to make medical decisions on my behalf in accordance with this directive:

Full Name: _____ Date of Birth: _____

Relation to Me: _____

Contact Number: _____ Email: _____

In the event that my primary Healthcare Representative is unable or unwilling to act, I designate the following alternates, in order of priority:

Name: _____ Relation: _____

Name: _____ Relation: _____

Contact: _____ Email: _____

I declare that this directive is executed voluntarily and is legally binding.

Healthcare providers and representatives acting in accordance with this directive shall be indemnified from legal liability. This directive remains valid across jurisdictions unless superseded by local laws.

I reserve the right to revoke or modify this directive at any time in writing, and the most recent signed version shall prevail.

I request that my family and physicians respect this directive as my final medical decision.

Signature of Executor: _____ Date: _____

Witness 1

Name: _____

Signature: _____

Address: _____

Date: _____

Witness 2

Name: _____

Signature: _____

Address: _____

Date: _____

This document was signed in my presence and attested on this date.

Name & Title of Notary/Gazetted Officer: _____

Signature: _____ Date: _____