Hawaii Living Will

HRS § 327E-3

DECLARATION

A. Statement of Declarant

Declaration made this _____ day of _____(month, year). I, _____, being of sound mind, and understanding that I have the right to request that my life be prolonged to the greatest extent possible, wilfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

My instructions shall prevail even if they create a conflict with the desires of my relatives, hospital policies, or the principles of those providing my care.

If I should develop a terminal condition or a permanent loss of the ability to communicate concerning medical treatment decisions, with no reasonable chance of regaining this ability, I do not want to have my life prolonged. I would not want to be subjected to surgery or resuscitation. Nor would I then wish to have life sustaining medicine or procedures. Instead, I request care, including medicine and procedures, for the purpose of providing comfort and pain relief.

CHECKLIST

I have also considered whether I want tube feeding to be provided and have selected one of the following provisions by putting a mark in the space provided:

☐ I do NOT want my life prolonged by tube or other artificial feeding or provision of fluids by a tube if my condition is as stated above.

☐ I DO want my life prolonged by tube or other artificial feeding and provision of fluids by a tube if my condition is as stated above.

If neither provision is selected or if both are selected, it shall be presumed that tube or other artificial feeding or provision of fluids by tube are requested to prolong the declarant's life.

This declaration shall control in all circumstances.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

Address _____

B. Statement of Witnesses

I am at least 18 years of age and not related to the declarant by blood, marriage, or adoption; and

not currently the attending physician, an employee of the attending physician, or an employee of the health care facility in which the declarant is a patient.

The declarant is personally known to me and I believe the declarant to be of sound mind.

Witness _____

Address _____

Witness _____

Address _____

C. Notarization

Subscribed, sworn to and acknowledged before me by _____, the declarant, and subscribed and sworn to before me by _____ and _____, witnesses, this _____ day of _____, 20__.

(SEAL) Signed _____

_____

(Official capacity of officer)

Hawaii Durable Power of Attorney for Healthcare Decisions

(1) **PART 1: DESIGNATION OF AGENT**: I designate the following individual as my agent to make healthcare decisions for me:

_____

(Name of individual you choose as agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a healthcare decision for me, I designate as my first alternate agent:

_____

(Name of individual you choose as first alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a healthcare decision for me, I designate as my second alternate agent:

_____

(Name of individual you choose as second alternate agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

(2) **AGENT'S AUTHORITY:** My agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, **except** as I state here:

(Add additional sheets if needed.)

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own healthcare decisions unless I mark the following box. If I mark this box ☐, my agent's authority to make healthcare decisions for me takes effect immediately.

(4) **AGENT'S OBLIGATION**: My agent shall make healthcare decisions for me in accordance with this power of attorney for healthcare, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make healthcare decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2: DONATION OF ORGANS AT DEATH (OPTIONAL)

(6) Upon my death: (mark applicable box)

☐ (a) I give any needed organs, tissues, or parts,

OR

☐ (b) I give the following organs, tissues, or parts only:

_____

☐ (c) My gift is for the following purposes:
(strike any of the following you do not want)
(i) Transplant
(ii) Therapy
(iii) Research
(iv) Education

PART 3: PRIMARY PHYSICIAN (OPTIONAL)

(7) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone) (phone)

(8) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

(9) **SIGNATURES:** Sign and date the form here:

_____ _____
(date) (sign your name)

_____ _____
(address) (print your name)

_____ _____
(city) (state)

(10) **WITNESSES:** This power of attorney will not be valid for making healthcare decisions unless it is either:
(a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature: or
(b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1 WITNESS

I declare under penalty of false swearing pursuant to *Section 710-1062, Hawaii Revised Statues*, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a healthcare provider, nor an employee of a healthcare provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____ _____
(city) (state)

WITNESS

I declare under penalty of false swearing pursuant to *Section 710-1062, Hawaii Revised Statutes*, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a healthcare provider, nor an employee of a healthcare provider or facility.

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____ _____
(city) (state)

ALTERNATIVE NO. 2

State of Hawaii

County of _____

On this _____ day of _____, in the year _____, before me, _____ (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal

_____
(Signature of Notary Public)

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