DIRECTIVE TO PHYSICIANS AS PROVIDED BY TEXAS NATURAL DEATH ACT
SECTION 3

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____. I _____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time I should have an incurable condition caused by injury, disease or illness certified to be a terminal condition by two physicians, and where the application of life- sustaining procedures would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

4. I have been diagnosed and notified at least 14 days ago as having a terminal condition by _____, M.D., whose address is _____, _____.

I understand that if I have not filed in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

5. This directive shall be in effect until revoked.

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

7. I understand that I may revoke this directive at any time.

Signed _____

City of residence: _____
County of residence: _____
State of residence: _____

The declarant has been personally known to me and I believe him or her to be of sound mind. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate on his decease, nor am I the attending physician of declarant or an employee of the attending physician or a health facility in which the declarant is a patient or any person who has a claim against any portion of the estate of the declarant upon his decease.

Witness:

_____

Witness:

_____

Witness:

_____

STATE OF TEXAS
COUNTY OF _____

Before me, the undersigned authority, on this day personally appeared _____, _____ and _____ and _____ known to me to be the declarant and witnesses whose names are subscribed to the foregoing instrument in their respective capacities, and, all of said persons being by me duly sworn, the declarant _____ declared to me and to the said witnesses in my presence that the said instrument is his Directive to Physicians, and that he willingly and voluntarily made and executed it as his free act and deed for the purposes therein expressed.

Declarant:

_____

Subscribed and acknowledged before me by the said Declarant _____ and by the said witnesses _____ and _____ on This _____ day of _____, 19_____.

_____
Notary Public in and for

_____ County, Texas