

**CATHOLIC DECLARATION ON LIFE AND DEATH  
ADVANCE DIRECTIVE  
(HEALTH SURROGATE DESIGNATION/LIVING WILL) OF**

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(Name)

**Introduction**

I am executing this *Catholic Declaration on Life and Death* while I am of sound mind. It is intended to clarify my wishes for treatment in situations that may arise in which I am incapacitated or unable to express these wishes.

**Statement of Faith**

I believe that I have been created for eternal life in union with God. The truth that my life is a precious gift from God has profound implications for the question of stewardship over my life. I have a duty to preserve my life and to use it for God's glory, but the duty to preserve my life is not absolute, for I may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.<sup>1</sup> If I should become irreversibly and terminally ill, I request to be fully informed of my condition so that I can prepare myself spiritually for death and witness to my belief in Christ's redemption.

**Designation of Health Care Surrogate**

In the event that I become incapacitated I designate as my surrogate for health care decisions (if no surrogate is to be appointed, please write "none" in place of "name" below):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phones (H, W, C): \_\_\_\_\_

If my surrogate is unwilling or unable to perform his or her duties or cannot be contacted, I wish to designate as my alternate surrogate (if no alternate surrogate is to be appointed, please write "none" in place of "name" below):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phones (H, W, C): \_\_\_\_\_

This directive will permit my surrogate to make health care decisions, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; to receive my personal health care information; and to authorize my admission to or transfer from a health care facility. It is not being made as a condition of treatment or admission to a health care facility. This document must be signed and witnessed on the other side to be valid.

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<sup>1</sup> Cf. United States Conference of Catholic Bishops, *Ethical & Religious Directives for Catholic Health Care Services* (USCCB: Washington, DC 2001), Part Five.

The following gives guidance for carrying out my wishes at the end of life. If at any time I am incapacitated and I have a terminal condition or I have an end-stage condition, and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition(s), my health care surrogate (designated above, if any) will be authorized to make decisions for me in accordance with my wishes expressed in this Declaration. If my surrogate cannot be contacted (or I have not named a surrogate), then I request and direct that each of the following be considered in making a decision for me.

That:

1. I be provided care and comfort, and that my pain be relieved;
2. No inappropriate, excessively burdensome nor disproportionate means be used to prolong my life. This can include medical or surgical procedures;
3. There should be a presumption in favor of providing nutrition and hydration to me, including medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to me;
4. Nothing be done with the intention of causing my death; and
5. Spiritual care be provided, including sacraments whenever possible.

#### **Additional Instructions**

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#### **Signatures Required**

It is my intention that my surrogate, family and physicians honor this declaration as the expression of my treatment wishes. I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

\_\_\_\_\_  
DECLARANT

Last 4 Social Security Number:\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Printed/Typed Name

\_\_\_\_\_  
Printed/Typed Name

The Health Care Surrogate cannot serve as a witness; at least one witness must not be a spouse or blood relative of the person signing.

January 1, 2005