LIVING WILL
(No Heroic Measures)
FOR
N-1

Pursuant to Arizona Revised Statute Sec. 36-3261 and effective immediately, I hereby create a Living Will in which I provide that my agent or agents designated below shall have authority to make decisions and implement my desires regarding my current or future medical care in the event that I become terminally or seriously ill as defined below. By completing this document, I revoke all prior living wills.

Appointment of agent. I appoint the following persons, to act as my agent for purposes of this Living Will:

1. N-2 – (relationship to N-1)
2. N-3 – (relationship to N-1)
3. N-4 – (relationship to N-1)

My agents are not required to be physically present when rendering a decision. Contact via telephone, email, text or by Skype or other similar electronic transmission is permitted. Neither the attending physician nor the hospital is required to determine if any or all of the above named persons have been consulted or contacted or the reason why certain individuals may not have been consulted or contacted. Any physician or other health care provider may rely on the avowal of authority of any agent acting on my behalf or on the behalf of other agents.

Resolution of Disputes. It is my intent and strong desire to avoid a "Terri Schiavo" situation. In the event that there is disagreement or dispute among my family members as to my intentions in matters governed by this Living Will, my duly authorized agents shall make the final and binding determination of what my intentions are or would be if I was capable of making my intentions known at that time.

Questions My Agents Should Ask of My Doctors. Before deciding on a course of action, I urge my agents to ask the following questions of my doctors:

Will the proposed treatment make a difference? If so, how?
What is the goal of the proposed treatment?
Do the burdens of the treatment outweigh its benefits and how did you determine this?
Is there hope of recovery? If so, what will life be like afterward?

Purpose and Intentions. Although I value life, I also believe that, due to injury, disease or having reached an advanced age, life has such diminished value that medical treatment should be stopped and that I should be allowed to die. I am completing this document so that my agent and family members can make the best decision with the least amount of guilt. I do not want my life extended by medical interventions, including artificially administered nutrition and hydration, when such treatments will not

improve or reverse my medical condition or otherwise give me a meaningful quality of life.

My agents, and only my agents, will make the decision as to when the burdens of treatment outweigh the benefits of treatment. In doing so, my agents shall consider the existence of the following factors that I have initialed to be indicative of a significantly diminished quality of life that could warrant the termination of medical care, except for the treatment of pain relief:

_____ Inability to make or communicate responsible decisions about my personal matters
_____ Inability to walk without the assistance of others or a wheel chair
_____ Experiencing pain most of the time
_____ Experiencing discomfort (such as nausea, diarrhea, shortness of breath or weakness) most of the time
_____ Inability to control my bladder and bowels
_____ Having a feeding tube inserted into my stomach and/or being unable to be fed by a spoon
_____ Having nutrition or hydration artificially provided to me, such as through a catheter or tube
_____ Use of a ventilator that is required to keep me alive
_____ Inability to recognize family or close friends
_____ Incurring costs for the provision of medical care that will create a financial hardship for me, my family or other loved ones

If I become terminally ill, I direct my agent to cease or withhold all medical interventions, except for the treatment of pain relief, if my doctors have diagnosed me as terminally ill *and* I am in an irreversible coma or persistent vegetative state.

For purposes of this paragraph, "terminally ill" means a condition that my doctors believe, to a reasonable degree of medical certainty, will result in my death within six months if my condition runs its normal course. For purposes of this document, a terminally ill condition includes a) a diagnosis of advanced or end-stage Alzheimer's disease or other form of dementia or b) any stroke, trauma to my brain or other severe brain injury that I may have suffered that will cause a permanent and significant loss of cognition, even though I realize that these conditions are not otherwise be considered to be terminal by the medical community.

Pain-free Death. I do not want my death to be painful. My doctors are authorized to provide to me medication of any type or form that can be administered by any medically acceptable means. I authorize the use of such medication even if the medication will have adverse cardiac or respiratory consequences, create an addiction, cause drowsiness, hallucinations or confusion or otherwise hasten my death.

Organ, Tissue and Parts Donation. Upon my death,

_____ I give any or all of my organs (such as brain, kidney, liver, heart, lung, pancreas, stomach and intestines) and tissues and body parts (such as skin, tendons, muscles, corneas, heart valves, veins, teeth and bone)

_____ I do **not** wish to donate any organs and tissue and body parts
_____ I give any or all of my organs but not tissues and my body parts

Lawsuits. My agent is authorized to initiate, defend or otherwise participate in any legal proceedings that may be necessary to implement my desires and the authority granted by me in this Living Will, to include litigation for injunctive relief and/or damages against any health care provider, family member or other individual or entity who fail to honor my desires as stated in this document.

HIPAA Release Authority. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

Copies. If the original copy of this Living Will has not or cannot be provided to my health care provider or other party, then any such provider or party may rely on a photocopy, digital image or other reproduction provided by Murphy Law Firm, Inc. that certifies that the copy is a true and accurate copy of the original.

_____ DATED this D-T, 2014

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I affirm that this was signed or acknowledged in my presence, and that the person signing this document (the Principal) appears to be of sound mind and under no duress. I am at least 18 years of age. I am not designated to make medical decisions on the Principal's behalf. I am not directly involved with the provision of health care to the Principal. I am not entitled to any portion of the Principal's estate upon his or her death, whether under any will or by operation of law. I am not related to the Principal by blood, marriage or adoption.

_____ DATED this D-T, 2014

W-1, Witness

STATE OF ARIZONA)
COUNTY OF MARICOPA) ss.

Subscribed, sworn to, and acknowledged before me by N-1 and subscribed and sworn to before me by W-1, a witness, this D-T, 2014.

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Thomas J. Murphy
Notary Public