

# Massachusetts: Living Will



NOTE: This form is being provided to you as a public service. The attached forms are provided “as is” and are not the substitute for the advice of an attorney. By providing these forms and information, Everplans is not providing legal advice to you. Consult an attorney if you need legal advice of any nature.

Read more and get more forms at Everplans’ [Advance Directive](#) page.

# LIVING WILL: MASSACHUSETTS

## A NOTE ABOUT THIS DOCUMENT

**Massachusetts is one of three states that do not recognize Living Wills, so this form will not be legally valid.**

However, a Living Will like this can still be invaluable in helping to guide your Health Care Proxy or other family members who may be responsible for your care decisions.

We have provided this form as an example based on Living Will forms from other states. You may make changes to this form or use any other form to better express your health care wishes.

## PART 1: TREATMENT PREFERENCES

### A. Statement of Goals and Values

Optional: Form valid if blank

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

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### B. Preference in Case of Terminal Condition

If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.

If my doctors certify that my death from a terminal condition is imminent, even if life - sustaining procedures are used:

1. \_\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.  
>OR<<
2. \_\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.  
>OR<<
3. \_\_\_\_\_ Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

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## C. Preference in Case of Persistent Vegetative State

If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. \_\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.  
**>OR<<**
2. \_\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.  
**>OR<<**
3. \_\_\_\_\_ Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means

## CI. Preference in Case of End - Stage Condition

If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.

If my doctors certify that I am in an end - state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. \_\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.  
**>OR<<**
2. \_\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.  
**>OR<<**
3. \_\_\_\_\_ Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

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## E. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

## F. In Case of Pregnancy

Optional, for women of childbearing years only; form valid if left blank

If I am pregnant, my decision concerning life-- sustaining procedures shall be modified as follows:

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## G. Effect of Stated Preferences

Read both of these statements carefully. Then, initial one only.

1. \_\_\_\_\_ I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

**>OR <<**

2. \_\_\_\_\_ I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

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## PART 2: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Declarant Month/Day/Year

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Witness 1 Month/Day/Year

\_\_\_\_\_  
Phone Number(s)

\_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Witness 2 Month/Day/Year

\_\_\_\_\_  
Phone Number(s)

Note: Anyone selected as a health care proxy should not be a witness. Also, at least one of the witnesses should be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Most states do not require this document to be notarized.