STATE OF SOUTH CAROLINA	<ul> <li>DECLARATION OF A DESIRE FOR A</li> <li>NATURAL DEATH</li> </ul>
COUNTY OF	)
I,, Declarant, domiciled in the City of Carolina, make this Declaration this	being at least eighteen years of age and a resident of and, County of, State of South, 20
prolong my dying if my condition is and I declare: If at any time I have a c who have personally examined me, of have determined that my death could use of life-sustaining procedures or unconsciousness and where the app prolong the dying process, I direct to	own my desire that no life-sustaining procedures be used to terminal or if I am in a state of permanent unconsciousness, condition certified to be a terminal condition by two physicians one of whom is my attending physician, and the physicians d occur within a reasonably short period of time without the if the physicians certify that I am in a state of permanent plication of life-sustaining procedures would serve only to hat the procedures be withheld or withdrawn, and that I be the administration of medication or the performance of any de me with comfort care.
INSTRUCTIONS CONCERNI	NG ARTIFICIAL NUTRITION AND HYDRATION
INITIAL ONE O	F THE FOLLOWING STATEMENTS
1. If my condition is terminal and co	ould result in death within a reasonably short time,
AI direct that nutrit indicated means, including medically	tion and hydration BE PROVIDED through any medically or surgically implanted tubes.
	rition and hydration NOT BE PROVIDED through any g medically or surgically implanted tubes.
	e standard South Carolina form. It has been added at the f clarification. If you do want it to apply, please initial the
Nevertheless, I do wand suffering and minimal intravenou	vant treatment to ensure my comfort and to relieve pain us fluids to avoid discomfort.
INITIAL ONE O	F THE FOLLOWING STATEMENTS
2. If I am in a persistent vegetative s	tate or other condition of permanent unconsciousness,
AI direct that nutrit indicated means, including medically	tion and hydration BE PROVIDED through any medically or surgically implanted tubes.

BI direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.					
The following line is not part of the standard South Carolina form. It has been added at the request of many people as a point of clarification. If you do want it to apply, please initial the line below:					
Nevertheless, I do want treatment to ensure my comfort and to relieve pain and suffering and minimal intravenous fluids to avoid discomfort.					
3. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.					
4. I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.					
APPOINTMENT OF AN AGENT (OPTIONAL)  1. You may give another person authority to revoke this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.  Name of Agent with Power to Revoke:  Address:  Telephone Number:					
2. You may give another person authority to enforce this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.  Name of Agent with Power to Enforce:  Address:  Telephone Number:					
REVOCATION PROCEDURES					

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN.

- (1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF YOUR INTENT TO REVOKE, BY YOU OR BY SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE ORIGINAL DECLARATIONS REVOKES ALL OF THE ORIGINAL DECLARATIONS;
- (2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE;

- (3) BY YOUR ORAL EXPRESSION OF YOUR INTENT TO REVOKE THE DECLARATION. AN ORAL REVOCATION COMMUNICATED TO THE ATTENDING PHYSICIAN BY A PERSON OTHER THAN YOU IS EFFECTIVE ONLY IF:
  - (A) THE PERSON WAS PRESENT WHEN THE ORAL REVOCATION WAS MADE;
  - (B) THE REVOCATION WAS COMMUNICATED TO THE PHYSICIAN WITHIN A REASONABLE TIME;
  - (C) YOUR PHYSICAL OR MENTAL CONDITION MAKES IT IMPOSSIBLE FOR THE PHYSICIAN TO CONFIRM THROUGH SUBSEQUENT CONVERSATION WITH YOU THAT THE REVOCATION HAS OCCURRED.

TO BE EFFECTIVE AS A REVOCATION, THE ORAL EXPRESSION CLEARLY MUST INDICATE YOUR DESIRE THAT THE DECLARATION NOT BE GIVEN EFFECT OR THAT LIFE-SUSTAINING PROCEDURES BE ADMINISTERED;

- (4) IF YOU, IN THE SPACE ABOVE, HAVE AUTHORIZED AN AGENT TO REVOKE THE DECLARATION, THE AGENT MAY REVOKE ORALLY OR BY A WRITTEN, SIGNED, AND DATED INSTRUMENT. AN AGENT MAY REVOKE ONLY IF YOU ARE INCOMPETENT TO DO SO. AN AGENT MAY REVOKE THE DECLARATION PERMANENTLY OR TEMPORARILY.
- (5) BY YOUR EXECUTING ANOTHER DECLARATION AT A LATER TIME.

	Declarant			
STATE OF SOUTH CAROLINA	)	AFFIDAVIT		
COUNTY OF	)	AFIDAVII		
We, witnesses to the foregoing Declara	and		, the	undersigned
witnesses to the foregoing Declara	tion, dated	this day of		, 20, at
least one of us being first duly swor	n, declare to	the undersigned author	rity, on the bas	sis of our best
information and belief, that the Decl	aration was	on that date signed by	the Declarant	as and for his
DECLARATION OF A DESIRE F request and in her presence, and in				,
on that date. The Declarant is person	onally know	n to us, and we believ	e her to be of	sound mind.
Each of us affirms that he/she is qua	lified as a wi	itness to this Declaration	n under the pro	ovisions of the
South Carolina Death With Dignity			-	
marriage, or adoption, either as a				•
Declarant, or spouse of any of th				
medical care; nor entitled to any po		, , ,		

any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the Declarant; nor the Declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the Declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the Declarant is a patient. If the Declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

Witness	Witness	
Subscribed, sworn to, and acknowledged be subscribed and sworn to before me by	efore me byand	, the Declarant, and
the witnesses, this day of	, 20	
		(SEAL)
	Notary Public for South Carolina My Commission Expires:	