

# Catholic Declaration on Life & Natural Death

*Prologue.* To my family, friends, physician, lawyer & pastor:

I am a Roman Catholic. I believe:

...in God the Father Almighty, and that my life and all creation is His loving gift;

...in Jesus Christ, His only Son, who suffered and died on the cross for my redemption;

...in the resurrection of the dead and the life of the world to come;

...in the Holy Catholic Church, and I desire to abide by her teachings for my whole life, from birth through natural death;

...that man is made in the image and likeness of God, and that each human person must therefore be accorded dignity and respect;

...that under God's providence, I am the steward of my life and must use all ordinary means to preserve it;

...that in accord with the teachings of the Church, I may legitimately refuse or discontinue extraordinary means to preserve my life.

Therefore, I pray that with Christ's help I may accept the joys and sorrows of life and natural death, follow the teachings of Christ and the Church and, by the grace of God, pass from this life into His eternal presence.

I pray also that my family, my friends and all the community of the Church will join me in this prayer, and continue to pray for me and all the departed that we may rest in eternal peace.

## Declaration

1. **Purpose.** This Catholic Declaration on Life and Natural Death, made while I am of sound mind, is provided as a means of making known my desires and directions regarding treatment or care for me in the event I become irreversibly or terminally ill. In the absence of my ability to give directions regarding any of the above, I intend that this Declaration shall be honored by my family and physician(s) as the final expression of my legal right to make decisions regarding medical or surgical treatment and accept the consequences for such decisions.

2. **Full Disclosure of Facts.** I admonish and direct my family, physicians, lawyer, pastor, and friends that, because of my Catholic belief in the dignity of the human person and my eternal destiny in God, if I become irreversibly, incurably, or terminally ill, I be informed fully of the facts so that spiritually I can prepare myself to die.

3. **General Presumption for Life.** This Declaration is to be interpreted in favor of continued life. I direct that health care decisions be made which are consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, or reduce or prevent the deterioration in, any physical or mental condition. I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental ability. I reject any action or omission that is intended to cause or hasten my death. If the instructions contained herein do not adequately address an issue concerning my medical treatment and care, those making decisions on my behalf should be guided generally by the pro-life teachings of the Catholic Church.

4. **Natural Death Instructions.** I have the right to make my own decisions concerning treatment that might inordinately prolong the dying process beyond the limits dictated by reason and good judgment. If I should have an incurable injury, disease or illness, certified to be a terminal condition by two physicians who have examined me (one of whom shall be my attending physician), and the physicians have determined, to the best of their professional ability, that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process; and if I am unable to make my own decisions and have no reasonable expectations of recovery, then I request and direct that no life-sustaining procedures be used to preserve my life. No means should be used with the intention of shortening my life. I intend for the term "life-sustaining procedure" to mean: any medical procedure or intervention which would only serve to prolong the dying process and where, in the judgment of the attending physician, natural death will occur whether or not such procedure or intervention is utilized.

5. **Comfort Care.** I direct that if I have a terminal condition as described above, I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care and relief of pain, even if such may have the known, but unintended side-effect of hastening my death.

6. **Nutrition and Hydration.** I believe that food (nutrition) and fluids (hydration) are not medical treatments, nor medical procedures, but ordinary means of preserving life. Therefore, I direct my health care provider(s) to provide me with food and fluids orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible. Furthermore, if at such time I am unable to eat and drink on my own (i.e. in a natural manner) food and fluids must be provided to me in an assisted manner (i.e. by tubes or a similar manner) unless: (a) my death is imminent (i.e. likely to happen without delay); or (b) I am unable to assimilate food or fluids; or (c) food or fluids endanger my condition.

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

Signed this \_\_\_\_ day of \_\_\_\_\_, 200\_\_.

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

\_\_\_\_\_  
Address

**NOTE: THIS DOCUMENT MUST BE WITNESSED BY EITHER 2 WITNESSES OR 1 NOTARY PUBLIC.**

The Declarant has been personally known to me and I believe the Declarant to be of sound mind. I did not sign the Declarant's signature above for or at the direction of the Declarant. I am not related to the Declarant by blood or marriage, entitled to any portion of the estate of the Declarant according to the laws of intestate succession or under any will of Declarant or codicil thereto, or directly financially responsible for Declarant's medical care.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

**-OR-**

STATE OF KANSAS, COUNTY OF \_\_\_\_\_, ss:

This instrument was acknowledged before me on the \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_, by -  
\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires:

Copy to: Family, Physician, Lawyer, Pastor