Psychiatric
Living Will

The following declaration should be signed and, where possible, witnessed, in addition to a notary public, by a trusted family member and/or confidant. Make several copies of the document with each copy notarized. Courts may not recognize the Living Will unless you have it filed with an attorney/lawyer, so provide a copy to your appointed legal representative and to each of the person(s) named below. It is also recommended that a copy of this be forwarded to CCHR International or nearest local CCHR chapter available at (www.cchr.org—global locator address). CCHR International's address is 6616 Sunset Blvd., Los Angeles, California, United States, 90028.

PSYCHIATRIC "LIVING WILL"
(Advance Protective Directive)

I, _____ born on _____

in _____, current address _____

_____

being of sound mind, willfully and voluntarily make known my desire that should it be so considered or decided that I be subject to involuntary incarceration or hospitalization (also known as committal and certification) in a psychiatric hospital, ward, facility, home or nursing home, and/or that I be subject to psychiatric procedures, including psychotropic drugs (including, but not limited to antipsychotics, antianxiety drugs, benzodiazepines, tranquilizers, antidepressants, psychostimulants or mood stabilizers) or any other physical or biological psychiatric therapy, I direct that such incarceration, hospitalization, treatment or procedures not be imposed, committed or used on me.

I refuse contact with and treatment by any psychiatrist, psychologist or other mental health practitioner as these practices, according to my personal, philosophic and/or religious convictions, do not adequately or properly diagnose and such diagnoses can constitute a false accusation about my behavior and/or beliefs and practices, are stigmatizing and therefore a threat to one's reputation and physical and mental well-being. Any of their treatments, given against my express wish, are an intrusion upon and thus an assault on my body and constitute, in my view, assault.

Among other situations, the above directions and positions apply in any case where my capacity or ability to give instructions may be or may be claimed to be impaired, or should I be in a state of unconsciousness, or should my communication in an actual and/or legal sense be impossible, or where any psychiatrist, psychologist, mental health practitioner, or law enforcement official or person asserts that the matter is a "life-saving" situation

requiring emergency intervention and/or treatment under any involuntary commitment law or similar legal authority.

In the absence of my ability to give further directions regarding the above, it is my intention that this declaration be honored by my family and physician(s) as an expression of my legal right to refuse medical, psychological, psychiatric or surgical treatment.

The lawyer mentioned below is appointed and authorized to institute appropriate proceedings on my behalf should the above declaration be violated and have my permission herewith to proceed with whatever criminal and/or civil procedures necessary to rectify such a violation.

I herewith authorize the following person(s) with the enforcement of this declaration of intention:

_____
(Name of lawyer/attorney)

_____
Contact information

_____
(Family member or other)

_____
Contact information

The declaration is also binding for my lawful agents, guardians, family, executors or any person with the legal or other right to take care of me or my affairs.

_____ _____
Signed Date

_____
Address

_____
Signature of notary/justice of the peace/attorney, etc.

_____
Name of notary, etc.

_____
Before me on this date (date notary witnessed the signature)

_____
at (place where signature is witnessed/notarized)