

DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, “the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a ‘scientific’ process.” Because of “political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective” (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that “The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow,” and suggesting that revised and enhanced documents “may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes” (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic professionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or “health care instruction” or “declaration”) and medical power of attorney (or “proxy”) forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, “*Should I Use a Shorter Standard Directive?*” available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

Lifecare Directives, LLC
5348 Vegas Drive
Las Vegas, NV 89108
www.lifecaredirectives.com
Toll Free: (877) 559-0527

~ Lifecare Directives ~



*Statutory
Advance Directive
For
Utah Residents*



*Statutory Compliant
Advance Directive for
Health Care Choices*

~ Lifecare Directives ~



*Statutory
Advance Directive
For
Utah Residents*



*Statutory Compliant
Advance Directive for
Health Care Choices*

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warranted to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Utah Residents

Print Full Name

Date of Birth

Your right (when age 18 or older): To Document Your Personal Wishes,
and to have these wishes followed ~~

The Utah state legislature has provided statutes guiding the construction of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as “advance directives.” As the content of these documents was designed by your state government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know your wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at **any** time by: **1)** writing “revoked” across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2)** by completing a Notice of Revocation; or **3)** by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4)** *by simply completing a new directive* in which you state that any prior directive is no longer valid.

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed after your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing “deleted” beside that clause or section, and placing your initials immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in three parts (presented in the order they appear in Utah statutes). You may choose to complete only **Section I**, leaving just a statement of your values and wishes in circumstances of a terminal condition or a persistent vegetative state. Or you may complete only **Section II**, naming someone to later complete Section II in your behalf after an illness or injury has been sustained. Or you may complete only **Section III**, *if* you are *already* suffering from a serious illness or injury. However, you are strongly encouraged to complete both Sections I and II now – or Section I and III, *if* you are already suffering from a serious condition for which life-sustaining treatment decisions must be made.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write “No,” “None,” or “Does Not Apply” in areas that would otherwise be left blank.

SECTION I:

DIRECTIVE TO PHYSICIANS

and Providers of Medical Services

(Pursuant to UCA Title 75: Ch. 2: Part II: §75-2-1104)

1. INTRODUCTION: *The Utah Directive to Physicians (living will) was designed to assist those wishing to refuse life-sustaining treatment in a terminal condition or persistent vegetative state (§75-2-1103(8),(10)).*

A “terminal” condition is defined as, “a condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the person” (§75-2-1103(10)).

A “persistent vegetative state” is defined as “a state of severe mental impairment, in which only involuntary bodily functions are present and the person totally lacks higher cortical and cognitive function but maintains vegetative brain stem processes for which there exists no reasonable expectation of regaining significant cognitive function...” (§75-2-1103(8)). Most people refer to this as a permanent coma.

Life-sustaining procedures are defined as, “any medical procedure or intervention which, when applied to a person who has been foundto have a terminal condition, would in the judgment of the attending physician serve only to prolong the dying process” (§75-2-1103(7)(a)). It includes food and water through tubes, unless otherwise directed by you. However, such treatments do not include “the administration of medication or sustenance, or the performance of any medical procedure deemed necessary to provide comfort care, or to alleviate pain” (§75-2-1103(6)(b)).

**DIRECTIVE TO PHYSICIANS
AND PROVIDERS OF MEDICAL SERVICES**

2. *Be it known that I, _____,*
being of sound mind, willfully and voluntarily make known my desire that (*line through
or cross out and initial any statement you do not agree with*):

- A) My life shall not be artificially prolonged by life-sustaining procedures except as I may otherwise provide in this directive.
- B) If at any time I should have an injury, disease, or illness, which is certified in writing to be a terminal condition by two physicians who have personally examined me, and in the opinion of those physicians the application of life-sustaining procedures would serve only to unnaturally prolong the moment of my death and to unnaturally postpone or prolong the dying process, I direct that these procedures be withheld or withdrawn and my death be permitted to occur naturally.
- C) I expressly intend this directive to be a final expression of my legal right to refuse medical or surgical treatment and to accept the consequences from this refusal, which shall remain in effect notwithstanding my future inability to give current medical directions to treating physicians and other providers of medical services.
- D) I understand that the term "life-sustaining procedure" includes artificial nutrition and hydration, *and any other procedures that I specify below*, to be considered life-sustaining, but does not include the administration of medication or the performance of any medical procedure which is intended to provide comfort care or to alleviate pain: _____

- 3. I reserve the right to give current medical directions to physicians and other providers of medical services so long as I am able, even though these directions may conflict with the above written directive that life-sustaining procedures be withheld or withdrawn.
- 4. I understand the full import of this directive and declare that I am emotionally and mentally competent to make this directive.

(Sign in the presence of two qualified witnesses, below)

5. Signed: _____

City: _____ County: _____

State: _____ ~ of residence.

Date: _____

Directive Witnesses

6. We witnesses certify that each of us is 18 years of age or older and each personally witnessed the declarant sign or direct the signing of this directive; that we are acquainted with the declarant and believe him to be of sound mind; that the declarant's desires are as expressed above; that neither of us is a person who signed the above directive on behalf of the declarant; that we are not related to the declarant by blood or marriage nor are we entitled to any portion of declarant's estate according to the laws of intestate succession of this state or under any will or codicil of declarant; that we are not directly financially responsible for declarant's medical care; and that we are not agents of any health care facility in which the declarant may be a patient at the time of signing this directive.

7. Witness 1: _____

Printed Name: _____

Address: _____

8. Witness 2: _____

Printed Name: _____

Address: _____

SECTION II:
SPECIAL POWER OF ATTORNEY
Designation of Health Care Agent

(Pursuant to UCA Title 75: Chapter 2: Part II: §75-2-1106)

24. INTRODUCTION: *A person 18 years of age or older, the "principal," may designate any other person 18 years of age or older to execute a directive under Section 75-2-1105 (a directive after illness or injury is incurred) on behalf of the principal after the principal incurs an injury, disease, or illness which renders him unable to make a directive, by executing a special power of attorney before a notary public. The person must be at least 18 years of age.*

25. ***Be it known that I:***

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

26. ~ this _____ day of _____, 20_____,
being of sound mind, do willfully and voluntarily appoint:

27. **Name of Agent:** _____

Address: _____

Telephone: Home: _____ Work: _____

Cell Phone or Pager: _____ E-mail: _____

28. ~ as my agent and attorney-in-fact, with lawful authority to execute a directive on my behalf under Section 75-2-1105, governing the care and treatment to be administered to or withheld from me at any time *after* I incur an injury, disease, or illness which renders me unable to give current directions to my attending physicians and other providers of medical services.

I have carefully selected my above-named agent with confidence in the belief that this person's familiarity with my desires, beliefs, and attitudes will result in directions to attending physicians and providers of medical services which would probably be the same as I would give if able to do so.

This power of attorney shall be and remain in effect from the time my attending physician certifies that I have incurred a physical or mental condition rendering me unable to give current directions to attending physicians and other providers of medical services as to my care and treatment.

29. _____
(Signature of Principal)

(Date)

CERTIFICATE OF NOTARY PUBLIC:

30. State of UTAH:

County of _____

On the _____ day of _____, 20_____,
personally appeared before me _____,
who duly acknowledged to me that he/she has read and fully understands the foregoing power of
attorney, executed the same of his/her own volition and for the purposes set forth, and that he/she
was acting under no constraint or undue influence whatsoever.

Signature of Notary Public

Address: _____

Date commission expires: _____ **SEAL:**

SECTION III:
DIRECTIVE TO PHYSICIANS
for Medical Services After Injury or Illness is Incurred
(Pursuant to UCA Title 75: Chapter 2: Part II: §75-2-1105)

9. INTRODUCTION: *A person 18 years of age or older may – “after incurring an injury, disease, or illness” (presumably of a terminal or serious nature, though not specified in the statute) – guide his or her care by means of a directive made under **this** section. Further, if he or she is no longer able to make medical decisions, choices may then be made between his or her physician and any “available person(s) acting as proxy” (though Section I, if previously completed and non-conflicting, will take priority in cases of terminal illness or a persistent vegetative state). Decisions so made and recorded here are binding upon providers of medical services.*

10. As a licensed Utah physician I (name), _____, certify that I am serving as the attending physician for:

11. Declarant’s Name: _____
Medical Record Number (if any): _____
Residence Address: _____
City: _____ County: _____
State: _____ Zip Code: _____

12. ~ who has been under my care since (date): _____

13. The above declarant is currently suffering from the following injury, disease, or illness:

14. I certify that I have explained to the declarant, to the extent he is able to understand, and to the available person(s) acting as proxy, the reasonable available alternatives for his or her care and treatment.

15. I certify that the care and treatment alternatives directed below are:

(indicate only one)

_____ (a) specifically directed by the declarant;

or,

_____ (b) that the declarant has a physical or mental condition which renders him unable to give personal directions for care and treatment and that the care and treatment alternatives directed below are in my opinion, and in the opinion of the

declarant's proxy, what the declarant would probably decide if able to give current directions concerning his care and treatment.

16. _____
Attending Physician Signature Date _____

Printed Name/Title Telephone _____

17. The following care and treatment or withholding of treatment is directed with respect to the declarant: _____

18. Signed: _____ Date: _____
At: (City) _____ (State) _____

19. Signature Assistance: *Have the following completed, only if the Declarant is unable to sign, above:* The principal's name, above, was signed by the person whose signature and name appear below, who is authorized by law to sign as a proxy on behalf of the Declarant:

20. Signature of Assistant: _____
Relationship to the Declarant: _____
Printed Name: _____ Date: _____
Address: _____
Telephone: Home: _____ Work: _____

Statement of Witnesses

21. We witnesses certify that each of us is 18 years of age or older; that we personally witnessed the declarant or a proxy sign this directive; that we are acquainted with the declarant and believe that care and treatment alternatives directed above are what the declarant has decided for himself concerning his care and treatment, or, if the foregoing was signed by a proxy, that we are acquainted with the proxy and believe that the proxy sincerely believes that the care and treatment alternatives directed above are what the declarant would probably decide for himself if he were able to give current directions concerning his care and treatment; that neither of us signed the above directive for or on behalf of declarant; that we are not related to the declarant by blood or marriage nor are we entitled to any portion of declarant's estate according to the laws of intestate succession of this state or under any will or codicil of the declarant; that we are not directly financially responsible for declarant's medical care; and that we are not agents of any health care facility in which declarant may be a patient at the time of signing this directive.

22. Witness #1: _____

Printed Name: _____

Address: _____

23. Witness #2: _____

Printed Name: _____

Address: _____