**Utah Living Will**

MY HEALTH CARE WISHES (LIVING WILL)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

Choose only one of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.

Option 1

\_\_\_\_\_\_\_\_ Initial

I choose to let my agent decide. I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.

Additional Comments:

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Option 2

\_\_\_\_\_\_\_\_ Initial

I choose to prolong life. Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.

Other:

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Option 3

\_\_\_\_\_\_\_\_ Initial

I choose not to receive care for the purpose of prolonging life, including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life.

If you choose this option, you must also choose either (a) or (b), below.

\_\_\_\_\_\_ Initial

(a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.

If you selected (a), above, do not choose any options under (b).

\_\_\_\_\_\_ Initial

(b) My health care provider should withhold or withdraw life-sustaining care if at least one of the following initialed conditions is met:

\_\_\_\_\_ I have a progressive illness that will cause death.

\_\_\_\_\_ I am close to death and am unlikely to recover.

\_\_\_\_\_ I cannot communicate and it is unlikely that my condition will improve.

\_\_\_\_\_ I do not recognize my friends or family and it is unlikely that my condition will improve.

\_\_\_\_\_ I am in a persistent vegetative state.

Other:

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Option 4

\_\_\_\_\_\_\_\_ Initial

I do not wish to express preferences about health care wishes in this directive.

Other:

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Additional instructions about your health care wishes:

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If you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health.

REVOKING OR CHANGING A DIRECTIVE

I may revoke or change this directive by:

1. Writing “void” across the form, or burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
2. Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
3. Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or
4. Signing a new directive. (If you sign more than one Advance Health Care Directive, the most recent one applies.)

MAKING MY DIRECTIVE LEGAL

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will that I have completed in the past.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, County, State of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESSES

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

1. related to the declarant by blood or marriage;
2. entitled to any portion of the declarant’s estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant;
3. a beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer on death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. entitled to benefit financially upon the death of the declarant;
5. entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. directly financially responsible for the declarant’s medical care;
7. a health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. the appointed agent or alternate agent.

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.

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