

How to use the Utah Will to Live Form – SUGGESTIONS AND REQUIREMENTS:

1. The document allows you to designate (name) a health care agent or attorney in fact – someone who will make health care decisions for you whenever you are unable to make or communicate them for yourself. It also allows you to give instructions concerning medical treatment decisions that the health care agent must follow. Any adult may designate a health care agent through this document. You can change your agent or alternate agent at any time.
2. It is helpful to designate a second health care agent to take over if your first choice is unable to serve. There is space on the form for you to designate a successor health care agent. Be sure to inform your agent and alternate agent of their being named and that they may be nominated as guardian or conservator for you.
3. Your health care agent must be at least 18 years of age.
4. The document will remain in effect until you revoke (cancel) it. You may revoke this document at any time. The revocation of the document may be oral, or written, or by destruction of the document. If the revocation is written, it must be signed and dated by you. (If you are unable to sign and date it yourself, you may direct someone to do it for you in your presence). If the revocation is oral, a witness at least 18 years of age must confirm your oral expression of an intent to revoke in writing and must sign and date this written confirmation. Commencement of proceedings for divorce, legal separation or annulment will revoke naming your spouse as your agent unless you have affirmed the intent to retain the agent subsequent to marital dissolution..
5. You should tell your doctor about this document. You should also ask your doctor to keep a copy of this document as a part of your medical health record. Give copies of the signed original to your health care agent, family members, and anyone else you think appropriate. Keep the original document in a safe place that will be easily accessible to others in case of an emergency and tell someone where it is.
6. This type of document has been authorized by the Utah Advance Health Care Directive Act, Utah Code Ann. § 75-2a-101 to 125 (2011).
7. You should periodically review your document to be sure it complies with your wishes. Before making any changes, be aware that it is possible that the statutes controlling this document have changed since this form was prepared. Contact the Will to Live Project by visiting www.nrlc.org (click on “Will to Live”) or an attorney to determine if this form can still be used.

8. If you have any questions about this document or want assistance filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit www.nrlc.org
and click on “Will to Live”

form prepared 2001
*clerical changes made 05/11

**Utah Advance Health Care Directive
Will to Live Form**

PART I: APPOINTMENT OF HEALTH CARE AGENT

When I am unable to decide or speak for myself, I trust and appoint:

Agent's Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: (____)_____ Cell Phone: (____)_____

to make health care decisions for me. This person is called my health care agent.

APPOINTMENT OF ALTERNATE HEALTH CARE AGENT:

If my health care agent is not reasonably available, I trust and appoint:

Agent's Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: (____)_____ Cell Phone: (____)_____

to be my health care agent instead.

PART II: HEALTH CARE INSTRUCTIONS

These instructions are for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care agent to make health care decisions 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, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care agent 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.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

–all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person’s death.

The instructions in this document are intended to be followed even if suicide is alleged to be attempted at some point after it is signed.

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 disability or the “quality” of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care agent to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my agent, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following my be withheld or withdrawn:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

WHEN I AM TERMINALLY ILL

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

C. OTHER SPECIAL CONDITIONS:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

IF I AM PREGNANT

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care attorney in fact(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

<p>If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.</p> <p style="text-align: right;">_____ Signature of Principal</p>

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 or power of attorney form, naming a health care agent, that I have completed in the past.

(Date)

(Signature)

(City, County, and State of Residence)

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.

(Signature of Witness)

(Printed Name of Witness)

(Street Address)

(City, State, and Zip Code)

Form prepared 2001
*clerical changes made 05/11