Utah Directive To Physicians And Providers Of Medical Services

Utah Code Ann. § 75-2-1104

This directive is made this _____day of _____, _____.

1. I, _____, being of sound mind, willfully and voluntarily make known my desire that my life not be artificially prolonged by life-sustaining procedures except as I may otherwise provide in this directive.

2. I declare that if at any time I should have an injury, disease, or illness, which is certified in writing to be a terminal condition or persistent vegetative state 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of my death and to unnaturally postpone or prolong the dying process, I direct that these procedures be withheld or withdrawn and my death be permitted to occur naturally.

3. 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.

4. 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:

5. 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though these directions may conflict with the above written directive that life-sustaining procedures be withheld or withdrawn.

6. I understand the full import of this directive and declare that I am emotionally and mentally competent to make this directive.

_____
Declarant's signature

_____
City, County, and State of Residence

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.

_____ _____
Signature of Witness Signature of Witness

_____ _____
Address of Witness Address of Witness

Utah Power of Attorney for Healthcare

I, _____,
(name)
of _____,
(address)
this _____ day of _____, _____, being of sound mind, willfully
(day) *(month)* *(year)*
and voluntarily appoint _____
(name of agent)
of _____
(address)
as my agent and attorney-in-fact, without substitution, 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 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.

_____
(*signature of principal)*

State of _____)
): ss.
County of _____)

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

_____
(*notary public)*
Residing at: _____

My commission expires:
_____

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