Utah Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.
I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will (My Health Care Wishes
[ ] Selection of Health Care Agent (My Agent)
[ ] Designation of Primary Physician
[ ] Organ Donation

PURSUANT TO UTAH CODE SECTION 75-2A-117

Part I: Allows you to record your wishes about health care in writing.
Part II: Allows you to name another person (and an alternate, if desired) to make health care decisions for you when you cannot make decisions or speak for yourself.
Part III: Tells you how to revoke the form.
Part IV: Allows you to designate your primary (and alternate , if desired) physician
Part V: Allows you to make an organ donation
Part VI: Makes your directive legal.

My Personal Information

Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ Cell Phone: _____

Birth date: _____

Part I: Living Will (My Health Care Wishes)

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

Choose one of the following by placing your initials before one of the four the statements that reflects your wishes.

[ ] 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. My agent may stop care that is prolonging my life only after the conditions checked "yes" below are met.

Yes _____ No _____ I have a progressive illness that will cause death.
Yes _____ No _____ I am close to death and am unlikely to recover.
Yes _____ No _____ I cannot communicate and it is unlikely that my condition will improve.
Yes _____ No _____ I am in a persistent vegetative state.
Yes _____ No _____ I do not recognize my friends or family and it is unlikely that my condition will improve.

[ ] I want to prolong life. Regardless of my condition or prognosis, I want my health care providers to try to keep me alive as long as possible, within the limits of generally accepted health care standards.

[ ] I choose NOT to receive care for the purpose of prolonging life, including food and fluids by tube, antibiotics, CPR, or dialysis 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. My health care provider may stop care that is prolonging my life only after the conditions checked "yes" below are met. If I check "no" to all the conditions, my health care provider should not provide care to prolong my life.

Yes _____ No _____ I have a progressive illness that will cause death.
Yes _____ No _____ I am close to death and am unlikely to recover.
Yes _____ No _____ I cannot communicate and it is unlikely that my condition will improve.
Yes _____ No _____ I am in a persistent vegetative state.
Yes _____ No _____ I do not recognize my friends or family and it is unlikely that my condition will improve.

[ ] I choose not to provide instructions about end-of-life care in this directive.

Additional or Other Instructions Regarding Choices: **(Add additional instructions if desired)**

Part II: My Agent

NO AGENT

[ ] I do not want to choose an agent. **Initial this paragraph if you do not want to name an agent, then go to Part III.** Do not name an agent below. No individual, organization, family member, health care provider, lawyer, or insurer should force you to name an agent.

If you would like to name a Health Care Agent, you may do so below:

MY AGENT
Agent's Name::_____
Street Address:_____
City, State, Zip:_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

ALTERNATE AGENT
Alternate Agent's Name:_____
Street Address:_____
City, State, Zip:_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

AGENT'S AUTHORITY: If I cannot make decisions or speak for myself, my agent can make any health care decision I could have made such as:

1. Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits later in Part II or in previously in Part I of this directive.
2. Hire and fire health care providers.
3. Ask questions and get answers from health care providers.
4. Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of this section.
5. Get copies of my medical records.
6. Ask for consultations or second opinions.

OTHER AUTHORITY: My agent has the powers below ONLY IF I place a check next to "yes" in the statement. I authorize my agent to:

Yes _____ NO _____ Get copies of my medical records at any time, even when I can speak for myself.

Yes _____ No _____ Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other congregate facility for long-term placement other than convalescent or recuperative care, unless I agree to be admitted at that time.

EXPANSION OR LIMITATIONS OF AUTHORITY: I wish to limit or expand the powers of my healthcare agent as follows:

NOMINATION OF GUARDIAN: Check "yes" or "no".

Yes _____ No _____ By appointing an agent in this document, I intend to avoid guardianship. If I must have a guardian, I want my agent to be my guardian.

CONSENT TO PARTICIPATE IN MEDICAL RESEARCH: Check "yes" or "no".

Yes _____ No _____ I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

CONSENT TO ORGAN DONATION: Check "yes" or "no".

Yes _____ No _____ If I have not otherwise agreed to organ donation (including in this document), then my agent may consent to the donation of my organs for the purpose of organ transplantation.

AGENT'S AUTHORITY TO OVERRIDE EXPRESSED WISHES: Check "yes" or "no".

Yes _____ No _____ My agent may make decisions about health care that are different from the instructions in Part I of this form.

Part III: Revoking My Directive

I may revoke this directive by:
1. Writing "void" across the form, or burning, tearing, or otherwise destroying or defacing the document or asking another person to do the same on my behalf;
2. Signing or directing another person to sign a written revocation on my behalf;
3. Stating that I wish to revoke the directive in the presence of a witness who meets the requirements of the witness in Part VI, below, and who will not be appointed as agent or become a default surrogate when the directive is revoked; or
4. Signing a new directive. (If you sign more than one Advance Health Care Directive, the most recent one applies.)

Part IV: Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Part V: Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

Part VI: Making My Directive Legal

I sign this Advance Health Care Directive voluntarily, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will (My Health Care Wishes)
[ ] Selection of Health Care Agent (My Agent)
[ ] Designation of Primary Physician
[ ] Organ Donation

I UNDERSTAND THE CHOICES I HAVE MADE. I DECLARE THAT I AM EMOTIONALLY AND MENTALLY ABLE TO MAKE THIS DIRECTIVE. BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____

On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent

I accept my appointment as Health Care Agent:

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent:

Signature _____ Date _____