DIRECTIVE TO PHYSICIANS AND PROVIDERS OF MEDICAL SERVICES
(LIVING WILL)
(Pursuant to Section 75-2-1104, UCA)

This directive is made this _____ day of __________, ______.

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.

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of my death and to unnaturally postpone or prolong the dying process, I direct that these procedures be withheld or withdrawn and my death be permitted to occur naturally.

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.

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:
____
____

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though these directions may conflict with the above written directive that life-sustaining procedures be withheld or withdrawn.

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

____
Declarant's Signature

____
Declarant's Name (please print)

____
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 interstate 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

____
Name of Witness (please print)

____
Address of Witness Address of Witness

____
Signature of Witness

____
Name of Witness (please print)

____
Address of Witness Address of Witness