

## **Idaho Durable Power of Attorney for Health Care Will to Live Form**

### **1. DESIGNATION OF HEALTH CARE AGENT**

I, (your name) \_\_\_\_\_

(your address) \_\_\_\_\_

(your phone number) \_\_\_\_\_

do hereby designate and appoint:

(Name of agent) \_\_\_\_\_

(address of agent) \_\_\_\_\_

(phone number(s) of agent) \_\_\_\_\_

*(insert name, address and telephone number(s) of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider; (2) a non-relative employee of your treating health care provider; (3) an operator of a community care facility; or (4) a non-relative employee of an operator of a community care facility.)*

as my attorney-in-fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical condition.

### **2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

By this document I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity.

### **3. GENERAL STATEMENT OF AUTHORITY GRANTED**

Subject to any limitations in this document, I hereby grant my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures. (If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in

paragraph 4, “Statement of Desires, Special Provisions, and Limitations,”) below. You can indicate your desires by including a statement of your desires in the same paragraph.

#### **4. STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS**

*(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below.

#### **GENERAL PRESUMPTION FOR LIFE**

I direct my health care provider(s) and health care attorney in fact(s) 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 attorney in fact 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.

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 attorney in fact to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my attorney in fact, as named below, 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 may be withheld or withdrawn:  
**(Be as specific as possible; SEE SUGGESTIONS.):**

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(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.):**

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(Cross off any remaining blank lines.)

**C. OTHER SPECIAL CONDITIONS:**

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

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(Cross off any remaining blank lines.)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**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 if 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.

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.

\_\_\_\_\_  
Signature of Declarant

**5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH**

Subject to any limitations in this document, my agent has the power and authority to do all of the following:

- (a) request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records;

- (b) execute on my behalf any releases or other documents that may be required in order to obtain this information;
- (c) consent to the disclosure of this information;
- (d) consent to the donation of any of my organs for medical purposes. (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.

## 6. SIGNING DOCUMENTS, WAIVERS AND RELEASES

Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

- (a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."
- (b) Any necessary waiver or release from liability required by a hospital or physician.

## 7. DESIGNATION OF ALTERNATE AGENTS

*(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that the agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if the marriage is dissolved.)*

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

### A. First Successor Agent

(successor agent's name) \_\_\_\_\_

(successor agent's address) \_\_\_\_\_

\_\_\_\_\_  
(successor agent's phone number) \_\_\_\_\_

### B. Second Successor Agent

(second successor agent's name) \_\_\_\_\_

(second successor agent's address) \_\_\_\_\_

\_\_\_\_\_  
(second successor agent's phone number) \_\_\_\_\_

## 8. PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

### DATE AND SIGNATURE OF PRINCIPAL

*(You must sign and date this power of attorney)*

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

in the city of \_\_\_\_\_, state of \_\_\_\_\_.

(Signature)\_\_\_\_\_

### SIGNATURE OF WITNESSES

*(This power of attorney will not be valid unless it is signed by two qualified witnesses who are present when you sign or acknowledge your signature. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this power of attorney.)*

This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.

I declare under penalty of perjury under the laws of Idaho that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document; and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

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

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

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

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

**TO BE SIGNED BY ONE OF THE WITNESSES:**

I further declare under penalty of perjury under the laws of Idaho that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing by operation of law.

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

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

**NOTARY PUBLIC**

*(The signer of this instrument may either have it witnessed as above or have his/her signature notarized as below, to legalize this instrument.*

State of Idaho

County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

before me, (name of notary public) \_\_\_\_\_

personally appeared, \_\_\_\_\_  
to me known (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the 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 Seal

Signature of Notary Public \_\_\_\_\_

My commission expires \_\_\_\_\_