**DOWNLOAD COVERSHEET**:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

*Lifecare Directives* staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

**Lifecare Directives, LLC**
5348 Vegas Drive
Las Vegas, NV 89108
www.lifecaredirectives.com
Toll Free: (877) 559-0527

~ Lifecare Directives ~

# Statutory Advance Directive

For

# Idaho Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ *Lifecare Directives* ~

# Statutory Advance Directive

For

## Idaho Residents

*Statutory Compliant Advance Directive for Health Care Choices*

***Important Notice***:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

# *Statutory Advance Directive For Idaho Residents*

____________________________ ________________________

*Print Full Name* *Date of Birth*

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***Your right*** *(when age 18 or older): To Document Your Personal Wishes,*
*and to have these wishes followed ~~*

The Idaho state legislature has provided statutes guiding the construction of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

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***Understanding Your Directive***

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

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***Instructions for Completing the Directive***:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

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## SECTION I:

# LIVING WILL DECLARATION

***and Personal Instructions***

(IRC Title 39: Ch.45: §39-4508 to §39-4514)

1. INTRODUCTION: *The Idaho living will was designed to assist those wishing to refuse life-sustaining treatment in a terminal and/or permanently unconscious condition (§39-4510(a)(b)). Before completing the directive, you should be aware of certain definitions. A terminal condition is defined as an, "injury, disease, illness or condition...[where] death is imminent, whether or not artificial life-sustaining procedures are utilized"(§39-4510(a)). A permanently unconscious condition is referred to as a "persistent vegetative state" and is often defined as a condition where the individual is entirely unresponsive to the environment in any meaningful way.*

   *Artificial life-sustaining procedures are defined as, "any medical procedure or intervention which utilizes mechanical means to sustain or supplant a vital function serving only to artificially prolong the moment of death..."(§39-4509). Included is "food and water through a...tube or intravenous line..." It is further noted, however, that life-sustaining treatments may not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain"(§39-4509).*

**LIVING WILL DECLARATION**
***A Directive to Withhold or to Provide Treatment***

2. I have chosen _not_ to complete a Living Will at this time, but I _do_ want to complete a comprehensive Health Care Power of Attorney (*skip to page 15*):
   Signature: ___________________________ Date: _______________________
   ***OR***:
3. I, ________________________________________________________, being of sound mind, and acting willingly and without duress, fraud or undue influence, herein direct that the instructions provided in Section I of this document are to be recognized as my Idaho Living Will and evidence of my health care treatment wishes. These instructions should be used to guide any physician, agent, attorney-in-fact, proxy, surrogate, representative, health care professional, family member, guardian, conservator, or other persons or entities providing, overseeing, or making medical decisions regarding my care in the event I am unable to make my wishes otherwise known.

4. ***Regarding Terminal Conditions***
   If I have been examined by two medical doctors, and diagnosed as being in a terminal condition, due to disease, illness or injury, and where my death is imminent, and where the use of artificial life-sustaining procedures would only prolong my dying, then:
   (*initial only _one_*)
   _____ *Request for continued medical treatment*: It is my desire that all medical treatment which will serve to effectively prolong my life and preserve or enhance my health be given to me, or continued if already begun. Such treatment shall include the administration of medications, procedures, therapies and techniques designed to ensure my comfort and freedom from pain or other distress as completely as is medically possible.
   ***OR***,
   _____ *Request for a natural death*. It is my desire that all medical treatments, procedures, therapies, techniques and medicines which may artificially prolong my dying be withheld and withdrawn, and that I be allowed to die from the natural processes of my terminal condition. I request only that those medications, procedures, therapies and techniques designed to ensure my comfort and freedom from pain or other distress be continued to the fullest extent they are effective.

5. Regarding the use of Artificial Nutrition (food) and Hydration (water).
   (*initial only _one_*)
   _____ *Request for continued artificial nutrition and hydration*. I request that artificial nutrition and hydration be continued, if the withholding or withdrawal would cause my death primarily from a lack of food or water.
   ***OR***,
   _____ *Request for withholding and withdrawal of artificial nutrition and/or*

*hydration*. I request that artificial nutrition and/or hydration be withheld or with drawn when I am already in a terminal condition, even if this may contribute to or cause my death, as specified below:

(*initial either or both, as they apply*)

_____ Nutrition (food) being administered through tubes, conduits, or other medical devices shall be withheld or withdrawn. However, liberal comfort care medications and procedures shall be used to ensure that I do not suffer from any lack of food.

_____ Hydration (water) being administered through tubes, conduits, or other medical devices shall be withheld or withdrawn. However, liberal comfort care medications and procedures shall be used to ensure that I do not suffer from any lack of water, and oral care shall be provided to keep my mouth and lips moist and clean.

(*If neither line above is initialed, then artificial nutrition and hydration will be given*)

6. ***Regarding Permanently Unconscious Conditions***

If I have been examined by two medical doctors (one of whom is specially qualified in evaluating unconscious conditions), and reliably diagnosed as being in a permanent coma or in a "persistent (permanent) vegetative state" (*a form of coma where eye-opening continues, but where no awareness of environment exists*), then:

(*initial only one*)

_____ *Request for continued medical treatment*: It is my desire that all medical treatment which will serve to effectively prolong my life and preserve or enhance my health be given to me, or continued if already begun. Such treatment shall include the administration of medications, procedures, therapies and techniques designed to ensure my comfort and freedom from pain or other distress as completely as is medically possible.

***OR***,

_____ *Request for a natural death*. It is my desire that all medical treatments, procedures, therapies, techniques and medicines which may artificially prolong my life in this condition be withheld and withdrawn. I request only that those medications, procedures, therapies and techniques designed to ensure my comfort and freedom from pain or other distress be continued to the fullest extent they are effective.

7. Regarding the use of Artificial Nutrition (food) and Hydration (water).

(*initial only one*)

_____ *Request for continued artificial nutrition and hydration*. I request that artificial nutrition and hydration be continued, if the withholding or withdrawal would cause my death primarily from a lack of food or water.

***OR***,

_____ *Request for withholding and withdrawal of artificial nutrition and/or hydration*. I request that artificial nutrition and/or hydration be withheld

or withdrawn when I am in a permanently unconscious condition, even if this may contribute to or cause my death, as specified below:

(*initial either or both, as they apply*)

_____ Nutrition (food) being administered through tubes, conduits, or other medical devices shall be withheld or withdrawn. However, liberal comfort care medications and procedures shall be used to ensure that I do not suffer from any lack of food.

_____ Hydration (water) being administered through tubes, conduits, or other medical devices shall be withheld or withdrawn. However, liberal comfort care medications and procedures shall be used to ensure that I do not suffer from any lack of water, and oral care shall be provided to keep my mouth and lips moist and clean.

(*If neither line above is initialed, then artificial nutrition and hydration will be given*)

8. Legal Limitations.

*Pregnancy*. Idaho statutes direct that a Living Will shall have "no force" during the course of a pregnancy. During this time, life-sustaining treatments must be given.

9. Other Instructions or limitations (*you may add additional instructions, if you so desire*):

_______________________________________________________________________
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10. ***Signature of Principal and Witnesses***:

These directions express my legal right to accept or refuse treatment under the laws of Idaho. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly otherwise indicating that I have changed my mind.

By signing below, I indicate that I am fully aware of the contents of this document, and understand its full purpose, effect, and import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*You should sign in the presence of* *two* *qualified adults; see below*)

11. Signed: ____________________________________________

Date: ____________________________________________

Address: ____________________________________________

***Statement of Witnesses***

12. I am at least 18 years of age and I know the principal personally. The principal has completed this document, and has affixed (or caused to have affixed) his/her signature or mark in my presence. This document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence. I have not signed the principal's signature (above) for or at the direction of the principal. I am not the a health care representative, agent, or proxy, nor a successor of such in any other directive document. I declare under penalty of perjury that I am not related to the principal by blood or marriage, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for the principal, and to the best of my knowledge I have no claim against nor am I entitled to any part of the individual's estate upon his or her death under a will or codicil now existing, nor by any other operation of law.

13. Witness: ____________________________________________

Printed Name:____________________________________________

Address: ____________________________________________

14. Witness: ____________________________________________

Printed Name:____________________________________________

Address: ____________________________________________

## SECTION II:
## DURABLE POWER OF ATTORNEY FOR HEALTH CARE
*and Personal Instructions*
*(IRC Title 39: Ch.45: §39-4508 to §39-4514)*

15. INTRODUCTION: *This section lets you name a person (called an "agent" or "attorney-in-fact") to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice.*

***Creation of Durable Power of Attorney for Health Care***

16. Be it known that I:
    Full Legal Name: ______________________________________________
    Date of Birth: ________________________________________________
    Street Address: _______________________________________________
    City: ___________________________ County: ______________________
    State: __________________________ Zip Code: ____________________

    ~~ Intend by this document to create a durable power of attorney for health care. This power of attorney shall not be affected by my later disability, incompetency, or incapacity (as the "principal" herein). I am of sound mind, and state that execution of this document is voluntary and without duress. Creation of this power of attorney is for the purpose of designating someone to act as my health care agent (also known as my attorney-in-fact), to act in my place to make medical decisions for me if I become unable to make them for myself . It also grants my agent the authority to make all legal and personal care decisions that I could make for myself, unless otherwise limited in this document. This designation is effective when, in the opinion of at least one licensed medical doctor who has personally examined me, I am no longer able make treatment decisions for myself. By creating this document I revoke any prior power of attorney for health care.

***Designation of Health Care Agent***:

17. I understand that I am not required to choose an agent, but that I am advised to do so to ensure that my wishes are fully represented and followed. Therefore:

(*initial only one*)

_____ I do not want to choose a health care agent at this time (*or I have no one appropriate for the task*). However, I instruct that Section I of this document be recognized as a declaration of my wishes within this Advance Health Care Directive (*proceed now to sign on page 7*);

***OR***,

_____ I do wish to appoint a health care agent. I recognize that, by Idaho law, this person may *not* be my treating health care provider nor a non-relative employee of my

health care provider;  nor may my agent be an operator of a community care facility or a non-relative employee of such an operator.  The person I have chosen to act as my agent and to whom I give **full** authority to make all medical and health care decisions for me at any time during which I am unable to make them for myself, is:

18. **Name of Agent**: ______________________________________________
Address: ___________________________________________________
Telephone: Home:____________________ Work:_____________________
Cell Phone or Pager: __________________ E-mail: ___________________

19. If for any reason I revoke the authority of my agent, or this individual is unavailable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternate agents:

20. **Name of Alternate #1:**_________________________________________
Address: ___________________________________________________
Telephone: Home:____________________ Work:_____________________
Cell Phone or Pager: __________________ E-mail: ___________________

21. **Name of Alternate #2:** ________________________________________
Address: ___________________________________________________
Telephone: Home:____________________ Work:_____________________
Cell Phone or Pager: __________________ E-mail: ___________________

22. Each alternate successor designated shall be vested with the same power and duties as if originally named as my health care agent.  These persons, *in priority of the order presented*, are to have binding authority over any and all other persons to make my personal and health care decisions.

***Decision-Making Guidelines***

23. In making decisions in my behalf *if my wishes are not otherwise clear (see my living will)*, I direct my agent to act in his/her best understanding of what my wishes would have been. And, where not reasonably sure of what I would have wanted, to act according to his/her belief in my interests as determined from his/her knowledge of my personal and family affairs, and other goals and values in life.  The authority of my agent shall not be terminated *unless* it appears that he or she is clearly and obviously not acting in accordance with my known wishes, or is overwhelmingly ignoring my best interests if my wishes are not otherwise known.

***Specific Authorities, Powers and Provisions***

24. This appointment shall extend to (but not be limited to) the following powers and authorities (*initial beside any power or authority you wish to include*):
    A. _____ Consent, refuse consent, renew or withdraw consent to any treatment, tests, medications, care, services, surgery or therapies used to diagnose or treat any physical or mental condition. This authorization includes the authority to consent to the provision, withholding or withdrawal of any life-sustaining treatment or procedure *even* if the consent or refusal of such will result in my death; **and** to legally act in *every* other matter related to my health and personal care with that same authority I would have, without incurring any personal, legal or financial liability for such.
    B. _____ Sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out my wishes and any of the powers as described in this document. This shall include "refusal of treatment" forms, and "discharge against medical advice" forms.
    C. _____ Request, review, receive, and disclose any medical information, verbal or written, needed to follow and manage my physical or mental health treatment and general care, and to authorize the release of my medical records or any other documentation needed to continue my treatment in or outside of any health care setting or service. This release authority applies to any information governed by the *Health Insurance Portability and Accountability Act of 1996 (HIPPA), 42 U.S.C. 1320d and 45 CFR 160 through 164*.
    D. _____ Consent to organ and/or tissue donation (or to donate my entire remains for medical or scientific research if I have indicated this is my wish).

    (*Any limitations or exclusions to your agent's authority should be noted below*)

***Additional Statement of Desires, Special Provisions, and Limitations***.

25. Noted below are any added limitations or other provisions which my health care agent must follow in acting in his or her representative capacity:

    26. *Living Will Declaration incorporation (if completed) and agent instructions (if appointed)*: I intend for my agent to follow, incorporate and enforce as medical and attorney-in-fact directives, any and all wishes as outlined in the Living Will Declaration contained in this advance directive document.

    27. *Other Wishes, Provisions, Treatments, and/or Limitations*: __________________
    ____________________________________________________________
    ____________________________________________________________
    ____________________________________________________________
    ____________________________________________________________
    ____________________________________________________________
    ____________________________________________________________

---

***Statement and Signature of Principal/grantor***

28. This document is governed by Idaho law, although I request that it be honored in any state in which I may be found.

By signing below, I indicate that I am fully aware of the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*You should sign in the presence of two qualified witnesses or a notary; see below*)

29. Signed:________________________________ Date: ______________________

At: (City) ______________________________ (State) ____________________

30. Signature Assistance: *Have the following completed, only if you (the "principal") are physically unable to sign*: The principal's name, above (and/or elsewhere within this document), was signed at his/her direction and in the presence of the principal and two witnesses, by the person whose signature and name appear below:

31. Signature of Assistant: __________________________________________
Printed Name:______________________ Date: ______________________
Address: ________________________________________________________
Telephone: Home: __________________ Work: _____________________

***Statement of Witnesses***

32. I am at least 18 years of age and I know the principal personally or have been provided convincing evidence of identity. The principal has affixed (or caused to be affixed) his/her signature or mark in my presence. It appears that this document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence. I have not signed the principal's signature (above) for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. I am not the agent or an alternate or successor named in this document. Further, I am not the attending physician or other treating health care provider, nor an employee of the physician or other health care provider. Nor am I an operator of a community care facility nor an employee of such, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for he principal, nor am I involved in directly physically caring for the principal, and to the best of my knowledge I have no claim against nor am I entitled to any part of the principal's estate upon his or her death under a will or codicil now existing, nor by any other operation of law.

33. 1st Witness: ______________________________________
(Signature)

______________________ ______________
(Name Printed) (Date)

______________________________________
(Residence Address)

34. 2nd Witness: ______________________________________
(Signature)

______________________ ______________
(Name Printed) (Date)

______________________________________
(Residence Address)

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***Certificate of Acknowledgment of Notary Public***:

35. State of Idaho,

County of______________________ }

On this_______day of ____________________________, in the year______, before me (insert officer name/title): _________________________________, personally appeared (insert name of Principal on line here):_______________________________, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____________________)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_________________________________
Signature of Notary Public

**Notary Seal:**

_________________________________
Date Commission Expires