

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

To my family, my relatives, my friends, my physicians, my employers, and all others whom it may concern:

Directive made this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

I, \_\_\_\_\_ (name), being of sound mind, willfully, and voluntarily make known my desire that my life shall not be prolonged artificially under the circumstances set forth below, do hereby declare:

1. If at any time I should have an incurable injury, disease, illness, or condition to be certified to be terminal by two medical doctors who have examined me, and where the application of life-sustaining procedures of any kind would serve only to prolong artificially the moment of my death, and where a medical doctor determines that my death is imminent, whether or not life-sustaining procedures are utilized, or I have been diagnosed as being in a persistent vegetative state, I direct that the following marked expression of my intent be followed and that I be permitted to die naturally, and that I receive any medical treatment or care that my be required to keep me free of pain or distress.

**Check ONE:**

\_\_\_\_\_ If at any time I should become unable to communicate my instructions, then I direct that all medical treatment, care, and nutrition and hydration necessary to restore my health, sustain my life, and to abolish or alleviate pain or distress be provided to me. Nutrition and hydration shall not be withheld or withdrawn from me if I would die from malnutrition or dehydration rather than from my injury, disease, illness or condition.

\_\_\_\_\_ If at any time I should become unable to communicate my instructions and where the application of artificial life-sustaining procedures shall serve only to prolong artificially the moment of my death, I direct such procedures be withheld or withdrawn except for the administration of nutrition and hydration.

\_\_\_\_\_ If at any time I should become unable to communicate my instructions and where the application of artificial life-sustaining procedures shall serve only to prolong artificially the moment of death, I direct such procedures be withheld or withdrawn including withdrawal of the administration of nutrition and hydration.

2. If the absence of my ability to give directions regarding the use of life-sustaining procedures, I hereby appoint \_\_\_\_\_ (name), currently residing \_\_\_\_\_

\_\_\_\_\_, as my attorney-in-fact/proxy for the making of decisions relating to my health care in my place; and it is my intention that this appointment shall be honored by him/her, by my family, relatives, friends, physicians, and lawyer as the final expression of my legal right

to refuse medical or surgical treatment; and I accept the consequences of such a decision. I have duly executed a Durable Power of Attorney for health care decisions on this date.

3. In the absence of my ability to give further directions regarding my treatment including life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse or accept medical and surgical treatment, and I accept the consequences of such refusal.

4. If I have been diagnosed as pregnant and that diagnosis is known to any interested person, this directive shall have no force during the course of my pregnancy.

5. I understand the full impact of this directive and am emotionally and mentally competent to make this directive. No participant in the making of this directive or in its being carried into effect, whether it be a medical doctor, my spouse, a relative, friend, or any other person shall be held responsible in any way, legally, professionally or socially, for complying with my directions.

Signed: \_\_\_\_\_

City, county, and state of residence: \_\_\_\_\_

\_\_\_\_\_

The declarant has been known to me personally and I believe him/her to be of sound mind.

Witness \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Witness \_\_\_\_\_

Address \_\_\_\_\_

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