

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____. I
_____, being of sound mind, willfully and
voluntarily make known my desire that my life shall not be
artificially prolonged under the circumstances below:

1. In the absence of my ability to give directions regarding the
use of artificial life-sustaining procedures as result of the
disease process of my terminal condition, it is my intention that
such artificial life-sustaining procedures should not be used when
they would serve only to artificially prolong the moment of my
death and where my physician determines that my death is imminent
whether or not life-sustaining procedures are utilized.

2. I have been diagnosed and notified that I have a terminal
condition known as _____ by _____ whose address is
_____, and whose telephone number is _____.

3. This directive shall have no force and effect five years from
the date filled in above.

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

Signed _____

STATE OF IDAHO

COUNTY OF _____

We, _____,

and _____, the qualified patient and the
witnesses respectively, who names are signed to the attached and
foregoing instrument, being first duly sworn, do hereby declare to
the undersigned authority that the qualified patient signed and
executed the directive and the he signed willingly and he executed
it as his free and voluntary act for the purposes therein
expressed; and that each of the witnesses, in the presence and
hearing of the qualified patient signed the directive as witness
and that to the best of his knowledge the qualified patient was at
the time 18 or more years of age, of sound mind and under no
constraint or undue influence. We the undersigned witnesses
further declare that we are not related to the qualified patient
by blood or marriage; that we are not entitled to any portion of

the estate of the qualified patient upon his decease under any will or codicil thereto presently existing or by operation of law then existing; that we are not the attending physician, an employee of the attending physician or a health facility in which the qualified patient is a patient, and that we are not a person who has a claim against any portion of the estate of the qualified patient upon his decease at the present time.

Qualified Patient

Subscribed, sworn to and acknowledged before me by

_____, the qualified patient, and subscribed

and sworn to before me by _____

and _____, witnesses, this _____ day of

_____, 19_____.

Notary Public for the State of Idaho

Residing at _____, Idaho