

Advanced Directive



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801-226-3500

Advanced Directive

- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
- Email Address: _____
- Emergency Contact Name: _____
- Relationship: _____
- Phone Number: _____

1. Healthcare Proxy (Durable Power of Attorney for Healthcare)

I hereby appoint the following person as my healthcare agent to make decisions on my behalf regarding medical treatment if I am unable to make or communicate decisions:

Healthcare Agent:

- Full Name: _____
- Relationship: _____
- Phone Number: _____

If the person named above is unable or unwilling to serve, I appoint the following person as my alternate healthcare agent:

Alternative Healthcare Agent:

- Full Name: _____
- Relationship: _____
- Phone Number: _____

2. Living Will (Declaration Regarding Medical Treatment)

If I am diagnosed with a terminal illness, a permanently unconscious state, or a condition from which there is no reasonable expectation of recovery, and I am unable to communicate my wishes, I direct the following:

A. Life-Sustaining Treatment

- I do **NOT** want life-sustaining treatment, including but not limited to CPR, mechanical ventilation, and feeding tubes.

- I want life-sustaining treatment to be administered to me for as long as possible, even if my condition is terminal or irreversible.
- I wish to have a decision made based on the circumstances at the time, considering the medical team's advice

B. Organ and Tissue Donation

- I consent to organ and tissue donation after my death for purposes of transplantation or medical research, if applicable.
- I do **NOT** consent to organ and tissue donation.

3. Funeral and Memorial Preferences

I hereby state my preferences for my funeral and memorial service. These preferences are to be followed by my family and loved ones, as much as possible, after my death.

A. Funeral Home of choice

- Walker Sanderson Funeral Home • Phone: 801-226-3500**
- Other _____

B. Type of Disposition

- I wish to be buried.
- I wish to be cremated.
- Other. _____

C. Funeral Service

- I prefer a traditional funeral service with viewing and burial.
- I prefer a memorial service without a body present.
- I prefer a celebration of life with personal elements, music, and stories from loved ones.

D. Final Resting Place

- I wish to be buried in the following cemetery or location: _____
- I would like my ashes to be scattered in a specific location: _____

4. Other Specific Wishes or Instructions

5. Signature

By signing this document, I confirm that I have the mental capacity to make decisions and that this document reflects my wishes and instructions for medical and funeral care.

Signature of Principal (Your Name): _____

Date: _____

6. Witnesses

I, the undersigned, declare that I witnessed the signing of the Advanced Directive by the above-named principal and that they appeared to be of sound mind and capable of understanding their decisions.

Witness 1:

- Full Name: _____
- Address: _____
- Phone Number: _____
- Signature: _____
- Date: _____

Witness 2:

- Full Name: _____
- Address: _____
- Phone Number: _____
- Signature: _____
- Date: _____

7. Notary Acknowledgement (Optional)

State of _____

County of _____

On this ____ day of _____, 20____, before me, a notary public, personally appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to this document and acknowledged that they executed the same for the purposes therein contained.

Notary Public: _____

My Commission Expires: _____