HEALTH CARE DIRECTIVE

I, _____ (name), living in the city of _____,

in the county of _____, in the state of _____,

make this Health Care Directive this _____ day of _____, 20_____

I, _____ (name), having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

1. If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

2. In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

3. If I am diagnosed to be in terminal condition or in a permanent unconscious condition (check one):

   ☐ I DO want to have artificially provided nutrition and hydration.

   ☐ I DO NOT want to have artificially provided nutrition and hydration.

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

5. I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

6. I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

7. It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

8. I make the following additional instructions regarding my care:

_____

_____

_____

_____

Washington State law requires that Health Care Directives be signed by the declarer in the presence of two witnesses.

Signature of Declarer_____

The declarer, who signed the above Directive, is personally known to me and I believe him or her to be capable of making health care decisions. I agree that I am not related to the declarer by blood or marriage, the declarer has stated I am not mentioned in the declarer's will, and I will not be entitled to any portion of the estate of the declarer upon declarer's decease under any existing will of the declarer at the time of the execution of the above Directive.

In addition, I am not the attending physician, an employee of the attending physician or a health care facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon the declarer's decease at the time of the execution of the above Directive.

_____	_____	_____
Date	Witness (print name)	Witness (signature)
_____	_____	_____
Date	Witness (print name)	Witness (signature)

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____ (name), living in the city of _____, in the county of _____, in the state of Washington, designate _____ (name) as my attorney in fact, to act for me in making health care decisions if I become incapacitated. I hereby revoke any and all health care powers of attorney previously granted by me.

1. **Alternate Attorney in Fact.** If for any reason _____ (name) fails to act, or is not able to act, I designate _____ (name), then _____ (name) as alternate attorneys in fact, to serve in the order named. An attorney in fact may resign by delivering written notice, in recordable form, to an alternate, successor, or co-attorney in fact. In this Durable Power of Attorney for Health Care, the "attorney in fact" means the then acting attorney in fact.

2. **Power to Make Health Care Decisions.** My attorney in fact shall have the right to make decisions, and to give informed consent on my behalf, as to my health care, to the extent permitted by law. This authority shall include, but not be limited to, the right to consent to the withholding or withdrawal of life-sustaining treatment which would only prolong artificially the moment of my death and prevent me from dying naturally, in those circumstances in which a physician(s) has/have determined (a) that I am in a permanent unconscious condition, meaning an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state, or (b) that I have a terminal condition, meaning an incurable and irreversible condition caused, by injury, disease or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards. I also authorize my attorney in fact to make decisions regarding the artificial administration of food and fluids, consistent with any Health Care Directive (living will) I have executed.

3. **Effectiveness.** This Durable Power of Attorney for Health Care shall become effective upon my incapacity. Incapacity shall include the inability to make health care decisions effectively for reasons such as mental illness, mental deficiency, incompetency, physical illness or disability, advanced age, chronic use of drugs or chronic intoxication. Incapacity may be determined by (a) a court order or (b) a written qualified attending physician.

4. **Duration.** This Durable Power of Attorney for Health Care becomes effective as provided in Section 3 above and shall remain in effect to the fullest extent permitted by Chapter 11.94 of the Revised Code of Washington, or until revoked or terminated as provided in Section 5 or 6 below.

5. **Revocation.** This Durable Power of Attorney for Health Care may be revoked, suspended, or terminated by written notice from me to the designated attorney in fact and, if this power has been recorded, by recording this notice in the office where deeds are recorded for real estate located in the _____County, Washington.

6. **Termination.** If appointed, my guardian may, with court approval, revoke, suspend, or terminate this Durable Power of Attorney for Health Care.

7. **Reliance.** Any person dealing with the assigned attorney in fact shall be entitled to rely upon this Durable Power of Attorney for Health Care to carry out my wishes for health care. No one shall deal with this attorney in fact if they know or have written notice of any cancellation, revocation, suspension, or termination of this Durable Power of Attorney for Health Care. Any action so taken, unless otherwise invalid or unenforceable, shall be binding on my relatives or inheritors of my estate.

8. **Indemnity.** My estate shall hold harmless and indemnify the attorney in fact from all liability for acts or omissions done in good faith.

9. **Applicable.** The laws of the State of Washington shall govern this Durable Power of Attorney for Health Care.

10. **Execution.** This Durable Power of Attorney for Health Care is signed on the _____day of _____, 20_____, to be effective as provided in Section 3 above.

Signature of Declarer_____

NOTE: Washington state law does not require a Durable Power of Attorney for Health Care be witnessed or notarized. However, it is recommended that there always be two witnesses and that these witnesses be persons qualified to witness the signing of a Health Care Directive. Such persons are individuals who are not related to the declarer by blood or marriage and who will not be entitled, under any existing will, to any portion of the estate of the declarer. Witnessing and/or notarization is also important as evidence to help confirm the declarer's competence and help assure that the declarer's wishes are carried out should family members of others oppose on the grounds the declarer did not understand what he/she was doing when signing the document.

_____	_____	_____
Date	Witness (print name)	Witness (signature)
_____	_____	_____
Date	Witness (print name)	Witness (signature)

Notarization, If Needed:

STATE OF WASHINGTON

COUNTY OF _____

I certify that I know or have satisfactory evidence that _____ signed this instrument and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in this instrument.

Dated this _____ day of _____ , 20_____.

_____

NOTARY PUBLIC in and for the State of Washington

Residing at _____

My commission expires _____