Washington Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will (Health Care Directive)
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Health Care Directive)

I, 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:

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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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.

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.

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

[ ] I DO want to have artificially-provided nutrition and hydration.
[ ] I do NOT want to have artificially-provided nutrition and hydration.

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. 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. I understand that before I sign this directive, I can add to, 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. 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.

Selection of Health Care Agent (Durable Power of Attorney for Health Care)

I understand that my wishes as expressed in my living will may not cover all possible aspects of my care if I become incapacitated. Consequently, there may be a need for someone to accept or refuse medical intervention on my behalf, in consultation with my physician. Therefore, I, designate and appoint _____ (name), of _____ (address), as my attorney-in-fact for health care decisions.

OPTIONAL - DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate attorney-in-fact:
_____ (name of individual you choose as alternate)
_____ (address)

This Power of Attorney shall take effect upon my incapacity to make my own health care decisions, as determined by my treating physician and one (1) other physician, and shall continue as long as the incapacity lasts or until I revoke it, whichever happens first.

The powers of my attorney-in-fact under this Power of Attorney are limited to making decisions about my health care on my behalf. These powers shall include the power to order the withholding or withdrawal of life-sustaining treatment if my attorney-in-fact believes, in his or her own judgment, that is what I would want if I could make the decision myself. The existence of this Durable Power of Attorney for Health Care shall have no effect upon the validity of any other Power of Attorney for other purposes that I have executed or may execute in the future.

In the event that a proceeding is initiated to appoint a guardian of my person under RCW 11.88, I nominate the person designated as my attorney-in-fact for health care decisions to serve as my guardian.

I make the following additional instructions regarding my care **(list instructions if desired)**:

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will (Health Care Directive
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____

On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care:

Signature of Agent _____ Date _____

Signature of Alternate _____ Date _____