WASHINGTON STATUTORY HEALTH CARE DIRECTIVE

Directive made this _____ day of _____ (month, year).

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:

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would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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

(b) 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.

(c) If I am diagnosed to be in a 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.

(d) 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.

(e) 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.

(f) 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.

(g) 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.

Signed _____

City, County, and State of Residence

The declarer has been personally known to me and I believe him or her to be capable of making health care decisions.

Witness _____

Witness _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice to Person Executing This Document

This is an important legal document. Before executing this document you should know these facts:

- This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you if you lose the capability to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself; you retain the right to make all medical and other health care decisions.

- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you.

- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedures to maintain, diagnose, or treat a physical or mental condition.

- A Health Care Agent will NEVER be allowed to authorize "mercy killing," euthanasia or any procedure, which would actually speed up the natural process of dying.

- When exercising his or her authority to make health care decisions for you, the Health Care Agent will have to act consistent with your express desires or, if they are unknown, in your best interest. You may express your desires to the Health Care Agent by including them in this document to my making them known in another manner.

- When acting under this document the Health Care Agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of healthcare records. You can limit that right in this document if you choose.

1. Creation of Durable Power of Attorney for Health Care

I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designed herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by RCW 11.94.010. This designation becomes effective when I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions.

2. Designation of Health Care Agent and Alternate Agents

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I designate and appoint

_____

(Name) (Address)

_____

(City, State, Zip Code) (Phone)

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care recognized in RCW 11.94.010 and authorize her or him to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that _____ is unable or unwilling to serve, I grant these powers to

_____

(Name) (Address)

_____

(City, State, Zip Code) (Phone)

In the event that both _____

and _____ are unable or unwilling to serve, I grant these powers to

_____

(Name) (Address)

_____

(City, State, Zip Code) (Phone)

3. General Statement of Authority Granted

My Health Care Agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in any Health Care Directive or other form of "living will" I may have executed or elsewhere, and to receive and consent to the release of medical information. When the Health Care Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making health care decisions.

The above authorization to make health care decisions does not include the following absent a court order:

1) Therapy or other procedure given for the purpose of inducing convulsion;
2) Surgery solely for the purpose of psychosurgery;
3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to the provisions of Chapter 71.05 RCW;
4) Sterilization

I hereby revoke any prior grants of durable power of attorney for health care.

4. Special Provisions

_____

_____

_____

_____

DATED this _____ day of _____, 20 _____

GRANTOR _____

STATE OF WASHINGTON)

)ss.

(COUNTY OF _____)

I certify that I know or have satisfactory evidence that the GRANTOR, _____ _____ Signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument. Dated this _____day of _____, 20___

_____

NOTARY PUBLIC in and for the State of Washington, residing at

_____

My commission expires _____