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.
- Your Health Care Agent should be someone you trust to make health care decisions on your behalf. Your Health Care Agent may be any adult, including relatives such as your spouse, state registered domestic partner, father, mother, adult child, or adult brother or sister. Unless they are one of the relatives listed above, your Health Care Agent may not be any of your physicians or your physicians' employees, or the owners, administrators or employees of a health care facility or long-term facility (as defined by RCW 43.190.020) where you reside or receive care.
- 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 procedure to maintain, diagnose, or treat a physical condition. You can limit that right in this document.
- When exercising authority to make health care decisions for you on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by including them in this document or 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 health care records.

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 designated 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 Washington law. This power of attorney shall become effective when I become disabled and 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. The Health Care Agent's power shall cease if and when I regain my capacity to make 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 _____Phone _____

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care recognized in Washington law 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 _____Phone _____

In the event that both _____and _____

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

Name_____Address _____

City _____ State_____ZIP _____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 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 _____, _____.
(Year)

GRANTOR: _____ GRANTOR'S SIGNATURE _____

NOTE: Washington state requires this directive to be witnessed by two people or acknowledged by a notary public.

WITNESS REQUIREMENTS: The witnesses to this document must be competent and must NOT be:

- Related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Your designated health care agent(s).

WITNESS _____ WITNESS _____

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this _____day of _____, _____

by _____.
(Name of individual)

_____
(Signature of notary public)

(Stamp)

_____
(Title of office)

My commission expires: _____

HEALTH CARE DIRECTIVE

Directive made this _____ day of _____, _____.
(Year)

I, _____being of sound mind, 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 have an incurable and irreversible condition certified to be a terminal condition by my attending physician, 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 "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.

(B) If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.

(C) If I am diagnosed to be in a terminal or permanent unconscious condition, [*Choose one*]

I want _____ do not want _____

artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.

(D) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

(E) 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.

(F) I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.

(G) I make the following additional directions regarding my care:

_____

_____

_____

_____

SIGNED: _____

Note: Washington state requires this directive to be witnessed by two people or acknowledged by a notary public.

WITNESS REQIREMENTS: The witnesses to this document must be competent and must NOT be:

- Related to you by blood or marriage.
- Entitled to any portion of your estate upon your death.
- Your attending physician or an employee of your attending physician or health care facility where you are a patient.
- Any person who has claim against any portion of your estate at the time of signature of this document.

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

WITNESS:_____ WITNESS: _____

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this _____day of _____, _____

by _____.
(Name of individual)

_____
(Signature of notary public)

(Stamp)

_____
(Title of office)

My commission expires: _____