HEALTH-CARE DIRECTIVE

Directive made this _____________day of _________________________, ______ (month, year) 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:

(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 for 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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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 terminal condition means 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 unreasonable probability of recovery from an irreversible coma or persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of a 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 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.

UW Medicine
Harborview Medical Center - UW Medical Center
University of Washington Physicians
Seattle, Washington

HEALTH CARE DIRECTIVE

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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 or delete from or otherwise change the wording of this directive and that I may add or delete from this directive at any time and that 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.

Signed _______________________________  Date __________________________

City, County, and State Residence

Date of Birth

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

Witness _______________________________  Date __________________________

Witness _______________________________  Date __________________________

[NOTE: Washington State law specifically prohibits an attending physician, his or her employees, or employees of 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 declarer’s decease at the time of the execution of the Directive from witnessing a Health-Care Directive; thus medical center staff, employees, and volunteers shall not witness this document.]
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 my resign be delivering written notice to that effect, 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 to 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 as recorded for real estate located in ______________________________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.


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 requires this directive to be notarized or witnessed by two different witnesses.

Witness _________________________________ Witness _____________________________________

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

- Home care providers for the individual completing this document;
- Care providers at an adult family home or long-term care facility if you live there; or
- Related to you or the designated Health Care Agent by blood, marriage, or state registered domestic partnership.

Notarization:

**STATE OF WASHINGTON**  
**COUNT OF________________________**

I certify that I know or have satisfactory evidence that the GRANTOR, signed this instrument and acknowledged it to be his/her free 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__________________________