Health Care Directive
of

_____

[My Name]

As a person with capacity, I willfully and voluntarily execute this Health Care Directive. In the absence of my ability to give directions regarding the use of life sustaining treatment, it is my intention that this directive shall be honored by my family and all medical providers as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences of such refusal. If I have appointed another person to make health care decisions for me, whether through a durable power of attorney or otherwise, then I request that my agent be guided by my desires as expressed in this directive or as otherwise communicated to my agent. 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.

1. Withhold and Withdraw Treatment. If at any time I should be diagnosed in writing to be in a terminal condition by my physician, or in a permanent unconscious condition by two physicians, and where the application of life sustaining treatment would serve only artificially to prolong the process of my dying, I direct that the following treatment be withheld or withdrawn: (*initial the choices that apply*)

   ____ Artificial nutrition.

   ____ Artificial hydration.

   ____ Artificial respiration.

   ____ Cardiopulmonary Resuscitation (CPR) , including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure.

   ____ Surgery to prolong my life or keep me alive.

   ____ Blood dialysis or filtration for lost kidney function.

   ____ Blood transfusion to replace lost or contaminated blood.

   ____ Medication used to prolong life, not for controlling pain.

   ____ Any other medical treatment used to prolong my life or keep me alive.

2. Comfort Care and Pain Medication. If at any time I should be diagnosed in writing to be in a terminal condition by my physician, or in a permanent unconscious condition by two physicians, I want treatment to relieve my pain and symptoms and make me comfortable if I appear to be in pain or experiencing other signs of discomfort, even if my physicians or other medical providers believe this might unintentionally hasten my death.

3. Health Care Institutions – Refusal to Honor My Advance Directive. If I am a patient at a health care institution whose policy is to decline to follow advance directives that conflict with certain religious or other beliefs when this document comes into effect, I direct that my consent to admission shall not constitute implied consent to procedures or courses of treatment that conflict with this advance directive. Moreover, if a health care institution declines to follow my wishes set out in the advance directive when this document comes into effect, I direct that I be transferred as soon as possible to a hospital, nursing home, or other institution that will honor the instructions provided in this document.

4. Changes and Revocation. I understand that, before I sign this directive, I can add to or delete from or otherwise change the wording of this directive. I further understand that at any time I may revoke this directive entirely or execute a new directive with different provisions. Any changes must be consistent with Washington State law or federal constitutional law to be legally valid.

5. Pregnancy. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive: (*initial the choice that applies*)

   ____ shall still have full force and effect during the course of my pregnancy.

   ____ shall have no force or effect during the course of my pregnancy.

6. Additional Directions: I make the following additional directions regarding my care:

I have signed this document in the presence of two (2) witnesses or a notary public.

_____ _____

My Signature Date

THIS FORM MUST BE SIGNED WITH TWO (2) WITNESSES OR A NOTARY PUBLIC

Statement of Witnesses

On _____, the maker of this document signed it in my presence. He or she is personally known to me and I believe him or her to be capable of making health care decisions, to understand this document, and to have signed it voluntarily.

- I am not related by blood or marriage to him or her.
- I am not now entitled to receive any portion of his or her estate, either by will or by operation of law, or as a result of any claim against him or her.
- I am not his or her attending physician or an employee of that physician or of a health facility in which he or she is a patient.

Witness 1	Witness 2
_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Phone	Phone
_____	_____
Address	Address

Notarization

State of Washington

County of _____

I certify that I know or have satisfactory evidence that_____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on _____.

_____
SIGNATURE OF NOTARY

_____
PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington.

My commission expires _____