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would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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

PT. NO.

NAME

DOB

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

HEALTH CARE DIRECTIVE

U0285

(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 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.

(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 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.]

PT. NO.

NAME

DOB

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

HEALTH CARE DIRECTIVE

U0285

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. **Agent**. In the event that my attending physician or their designee determines that I am not capable of giving informed consent to health care, I ___________________________, designate and appoint _______________________________as my attorney-in-fact (Health Care Agent).

2. **Alternate Agent (optional)**. If the above-named Health Care Agent is unable or unwilling to act or not reasonably available, I designate and appoint _______________________________as my alternate attorney-in-fact (alternate Health Care Agent). **(Optional)** If the above-named alternate Health Care Agent is unable or unwilling to act or not reasonably available, I designate and appoint _______________________________as my alternate attorney-in-fact (alternate Health Care Agent).

3. **Authority of Health Care Agent**. My Health Care Agent is authorized to make decisions about my health care treatment that I am otherwise not able to make. This includes but is not limited to consent to initiate, continue, discontinue, or refuse medical care and treatment, as well as healthcare coordination. This includes artificial nutrition or hydration, surgical procedures and the withholding or withdrawal of life sustaining treatments. If I have executed an advance directive or living will, I authorize and direct my Health Care Agent to follow these directions. If I have not stated any wishes or desires, my Health Care Agent should act in my best interest.

4. **My Rights**. I keep the right to make health care decisions for myself as long as I am capable. This power of attorney will become effective only when I am unable to make health care decisions for myself as determined by my attending physician or their designee. My designated Health Care Agent's power will cease if and when I regain my capacity to make health care decisions as determined by my attending physician or their designee.

5. **Durable**. I intend to create a durable health care power of attorney. This power of attorney shall not be affected by my disability.

6. **End Date**. This health care power of attorney will terminate if I revoke it or when I die.

7. **Revocation**. I hereby revoke any prior grants of durable power of attorney for health care I have signed in the past. Should such prior durable power of attorney for health care exist in a document containing other grants of powers of attorney, I intend this document to revoke only the health care grants of power.

Signed ___________________________________ Date _________________

FORM CONTINUES ON NEXT PAGE

PLACE PATIENT LABEL HERE

NOTARIZATION

State of Washington County of ________________________

I certify that I know or have satisfactory evidence that the Grantor,__________________________________, 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: _____________________________________

WITNESSES

In lieu of notarization, this document may be witnessed by two competent persons who are NOT:

- Home care providers for the principal;
- Care providers at an adult family home or long-term care facility in which the principal resides; or
- Related to the principal or any designated Health Care Agent by blood, marriage, or state registered domestic partnership.

Witness Name ________________________ Signature____________________

Witness Name ________________________ Signature____________________

Contact Information (Optional)

Agent Name:	Agent Telephone Number:	Other Contact Information:
Alternate Agent Name:	Alternate Agent Telephone Number:	Other Contact Information:

PLACE PATIENT LABEL HERE

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

If you are unable to make informed health care decisions for yourself, you can designate others to make those decisions for you. In order of priority, Washington state law (RCW 7.70.065) gives this authority to:

1. A court-appointed guardian;
2. The person you granted a durable power of attorney for health care decisions;
3. Your spouse or state registered domestic partner;
4. Your children who are over the age of eighteen, if all agree on a decision;
5. Your parents, if all agree on a decision; then
6. Your adult brothers and sisters, if all agree on a decision.

A durable power of attorney (DPOA) for health care is the legal document that allows you to choose the person you would like to make health care decisions for you. It can be any adult you trust, including a close friend or other relative. Your physician or their employees, or the owners, administrators or employees of a health care or long-term care facility where you receive care cannot be appointed unless they are related to you.

The person you appoint as your health care agent must make decisions consistent with your wishes, or if they are unknown, in your best interest. This may include decisions to initiate, continue, discontinue or refuse medical care and treatment. This includes artificial nutrition or hydration, surgical procedures, and the withholding or withdrawal of life sustaining treatments. It is important that you discuss your wishes with the person(s) you designate as your agent. You may want to complete an Advance Directive for Health Care to memorialize these discussions and your preferences. Your provider can give you more information about that form.

A DPOA for health care may take many forms. The attached form is a sample which, when properly completed, becomes effective only when you are unable to make your own health care decisions. You may choose to use this DPOA form or any other legally sufficient form you wish. Washington State requires this directive to be notarized or witnessed by two different witnesses. Although we provide this for your convenience, we cannot assure the validity of the form.

This is not intended as a substitute for legal advice. Should you have any questions about DPOA for health care, including completing this form, please contact an attorney. If you would like assistance in locating an attorney, including low cost or legal aid options, you can contact the King County Bar Association at (206) 267-7010. You may also visit www.washingtonlawhelp.org for free legal information and self-help materials.

PLACE PATIENT LABEL HERE