Health Care Directive

Directive made this _____day of _____, in the year 20____ .

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. I 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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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 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 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 Health Care 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 for Health Care or otherwise, I request that the person be guided by this Health Care 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. _____ Initial

☐ I DO NOT want to have artificially provided nutrition and hydration. _____ Initial

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this Health Care Directive shall have no force or effect during the course of my pregnancy.

(e) I understand the full import of this Health Care Directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

Continued on reverse

(f) I understand that before I sign this Health Care Directive, I can add to or delete from or otherwise change the wording of this Health Care Directive and that I may add to or delete from this Health Care 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 Health Care Directive be fully implemented. If for any reason any part is held invalid, it is my wish that the remainder of my Health Care Directive be implemented.

Signed: _____

_____

Address

_____

City, County and State of Residence

To Be Read By Witness Before Signing

I am not the attending physician, an employee of the attending physician or health facility in which the declarer is a patient, not related by blood or marriage, or a person who has a claim against any portion of the estate of the declarer upon the declarer's death, at the time of the execution of the directive.

1. Witness: (Print your name)	(Sign your name)
2. Witness: (Print your name)	(Sign your name)

Additional comments, if any: