ADVANCE DIRECTIVE FOR HEALTH CARE

Directive made this _____ day of _____, _____.
(month) (year)

I, _____, having the capacity to make my own health care decisions, 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 an advanced phase of a terminal condition by my attending physician, or in a permanent unconscious condition by two physicians qualified to assess me, and if the application of life sustaining treatment would serve only to prolong artificially the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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 a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, which would, within reasonable medical judgement, 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 judgement, as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

In the absence of my ability to give directions regarding the use of such 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 for Health Care or otherwise, I request that the person be guided by this Directive and any other clear expressions of my desires.

B. If I am diagnosed to be in an advanced phase of a terminal condition or in a permanent unconscious condition *(initial & date selection):*

I ***do*** want to have artificially provided nutrition
_____ *(initial)* _____ *(date)*
I ***do not*** want to have artificially provided nutrition
_____ *(initial)* _____ *(date)*

C. If I am diagnosed to be in an advanced phase of a terminal condition or in a permanent unconscious condition *(initial & date selection):*

I ***do*** want to have artificially provided hydration
_____ *(initial)* _____ *(date)*
I ***do not*** want to have artificially provided hydration
_____ *(initial)* _____ *(date)*

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 impact 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; that I may destroy, revoke or alter this 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 Directive be fully implemented. If, for any reason, any part is held invalid, it is my wish that the remainder of this Directive be implemented.

H. I make the following additional directions regarding my care:

_____
_____
_____
_____

Signed_____ Date_____

Social Security Number _____

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

Witness _____

Witness _____

A witness must not be:

- Related to the declarer by blood or marriage;
- Entitled to any portion of the estate of the declarer upon the declarer's death under any will of the declarer or by the operation of law then existing;
- The attending physician or an employee of the attending physician or the health care facility in which the declarer is admitted;
- A person who has a claim against any portion of the declarer's estate upon the declarer's death at the time of signing.