

HEALTH CARE DIRECTIVE INSTRUCTIONS

1. Spend some time thinking about whether or not you want life-sustaining treatment should you become terminally ill if such treatment would only prolong the process of dying.
2. If you do not want such treatment used, carefully read the Health Care Directive document to ensure you agree with it.
3. At the end of paragraph (c), you have the option of also consenting to withholding and withdrawal of artificial hydration and nutrition by inserting your initials in the box provided.
4. You must be 18 years of age or older to sign the Directive. The document must be signed by you in the presence of two witnesses.
5. Note that there are restrictions on who can witness the Directive. Witnesses may not be:
 - Related to you by blood, marriage or adoption;
 - Entitled to any portion of your estate or have any claim on it; or
 - A physician attending you, a person employed by such a physician, or someone employed by a health care facility in which you are a patient.
6. The original signed and witnessed copy should be put in a place of safe keeping accessible to someone other than yourself. More importantly, copies should be given to your close family members, physician(s), attorney, spiritual advisor, and any others who may be called upon to act on your behalf should you be unable to do so. Each copy should state where the original is kept, and who else has copies. You should bring a copy with you each time you are admitted to a hospital.
7. Any special comments regarding your wishes concerning life-sustaining treatment should be attached to the official Health Care Directive document. These do not have to be witnessed, but it is preferable to do so. You should discuss any special comments with your physician and lawyer.
8. If you wish advice or have questions regarding a Health Care Directive, you are urged to contact your lawyer.

HEALTH CARE DIRECTIVE

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

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, 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 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 by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that 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 in using this form 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.

(b) 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 from 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 a terminal condition or in a permanent unconscious condition **(initial one only)**:

I DO want to have artificially provided nutrition and hydration

I DO NOT want to have artificially provided nutrition and hydration

(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 to or delete from 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 my directive be implemented.
Signed at _____, Washington, on _____, 20_____.

Signature

Social Security Number or Birthdate

The declarer has been personally known to me and I believe _____ to be capable of making health care decisions. I affirm that I am not related to the declarer by blood or marriage, that the declarer has stated I am not mentioned in his or her will, that I am not entitled to receive any portion of the declarer's estate by operation of law, that I have no claim against the declarer, and that I am not an employee or an attending physician of the declarer or of the health care facility (if any) in which the declarer is a patient.

Witness _____ Address _____

Witness _____ Address _____
