

PowerForm Signer Information

Please enter your name and email to begin the signing process.

Your Role:

Originator

Your Name:

Your Email:

Please provide information for any other signers needed for this document.

Role:

Witness 1

Name:

Email:

Role:

Witness 2

Name:

Email:

Role:

Physician

Name:

Email:

[Begin Signing](#)

If there are other roles required for this document to be completed, please enter the name and email of those other recipients. An email will be sent inviting them to sign along with you.

HEALTH CARE DIRECTIVE

I, EXAMPLE (name), living in the city of _____,
in the county of _____, in the state of _____,
make this Health Care Directive this _____ day of _____, 20_____

I, EXAMPLE (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:

1. 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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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 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 no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.
2. 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 or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.
3. 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.
4. 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.
5. 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.

- 6. 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.
- 7. 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.
- 8. I make the following additional instructions regarding my care:

Washington State law requires that Health Care Directives be signed by the declarer in the presence of two witnesses.

In Process

Signature of Declarer _____

The declarer, who signed the above Directive, is personally known to me and I believe him or her to be capable of making health care decisions. I agree that I am not related to the declarer by blood or marriage, the declarer has stated I am not mentioned in the declarer's will, and I will not be entitled to any portion of the estate of the declarer upon declarer's decease under any existing will of the declarer at the time of the execution of the above Directive.

In addition, I am not the attending physician, an employee of the attending physician or 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 the declarer's decease at the time of the execution of the above Directive.

Date	Witness (print name)	Witness (signature)
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Date	Witness (print name)	Witness (signature)
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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, EXAMPLE (name), living in the city of _____, in the county of _____, in the state of Washington, designate _____ (name) as my attorney in fact, to act for me in making health care decisions if I become incapacitated. I hereby revoke any and all health care powers of attorney previously granted by me.

1. **Alternate Attorney in Fact.** If for any reason _____ (name) fails to act, or is not able to act, I designate _____ (name), then _____ (name) as alternate attorneys in fact, to serve in the order named. An attorney in fact may resign by delivering written notice, in recordable form, to an alternate, successor, or co-attorney in fact. In this Durable Power of Attorney for Health Care, the “attorney in fact” means the then acting attorney in fact.

2. **Power to Make Health Care Decisions.** My attorney in fact shall have the right to make decisions, and to give informed consent on my behalf, as to my health care, to the extent permitted by law. This authority shall include, but not be limited to, the right to consent to the withholding or withdrawal of life-sustaining treatment which would only prolong artificially the moment of my death and prevent me from dying naturally, in those circumstances in which a physician(s) has/have determined (a) that I am in a permanent unconscious condition, meaning 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, or (b) that I have a terminal condition, meaning 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. I also authorize my attorney in fact to make decisions regarding the artificial administration of food and fluids, consistent with any Health Care Directive (living will) I have executed.

3. **Effectiveness.** This Durable Power of Attorney for Health Care shall become effective upon my incapacity. Incapacity shall include the inability to make health care decisions effectively for reasons such as mental illness, mental deficiency, incompetency, physical illness or disability, advanced age, chronic use of drugs or chronic intoxication. Incapacity may be determined by (a) a court order or (b) a written qualified attending physician.

4. **Duration.** This Durable Power of Attorney for Health Care becomes effective as provided in Section 3 above and shall remain in effect to the fullest extent permitted by Chapter 11.94 of the Revised Code of Washington, or until revoked or terminated as provided in Section 5 or 6 below.

5. **Revocation.** This Durable Power of Attorney for Health Care may be revoked, suspended, or terminated by written notice from me to the designated attorney in fact and, if this power has been recorded, by recording this notice in the office where deeds are recorded for real estate located in the _____ County, Washington.
6. **Termination.** If appointed, my guardian may, with court approval, revoke, suspend, or terminate this Durable Power of Attorney for Health Care.
7. **Reliance.** Any person dealing with the assigned attorney in fact shall be entitled to rely upon this Durable Power of Attorney for Health Care to carry out my wishes for health care. No one shall deal with this attorney in fact if they know or have written notice of any cancellation, revocation, suspension, or termination of this Durable Power of Attorney for Health Care. Any action so taken, unless otherwise invalid or unenforceable, shall be binding on my relatives or inheritors of my estate.
8. **Indemnity.** My estate shall hold harmless and indemnify the attorney in fact from all liability for acts or omissions done in good faith.
9. **Applicable.** The laws of the State of Washington shall govern this Durable Power of Attorney for Health Care.
10. **Execution.** This Durable Power of Attorney for Health Care is signed on the _____ day of _____, 20____, to be effective as provided in Section 3 above.

Signature of Declarer _____

NOTE: Washington state law does not require a Durable Power of Attorney for Health Care be witnessed or notarized. However, it is recommended that there always be two witnesses and that these witnesses be persons qualified to witness the signing of a Health Care Directive. Such persons are individuals who are not related to the declarer by blood or marriage and who will not be entitled, under any existing will, to any portion of the estate of the declarer. Witnessing and/or notarization is also important as evidence to help confirm the declarer's competence and help assure that the declarer's wishes are carried out should family members or others oppose on the grounds the declarer did not understand what he/she was doing when signing the document.

_____	_____	_____
Date	Witness (print name)	Witness (signature)
_____	_____	_____
Date	Witness (print name)	Witness (signature)

Notarization, If Needed:

STATE OF WASHINGTON

COUNTY OF _____

I certify that I know or have satisfactory evidence that _____ signed this instr

Dated this _____ day of _____, 20_____.

NOTARY PUBLIC in and for the State of Washington

Residing at _____

My commission expires _____

In Process



A letter to my loved ones...

Dear Loved Ones,

*I want the best quality of life possible during my last days.
Therefore, I hereby request as follows...*

(a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.

(b) If my temperature is above normal, I want a cool moist cloth put on my head.

(c) I want my mouth and lips kept moist.

(d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.

(e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.

(f) I want my personal care such as nail clipping, hair combing, teeth brushing and shaving as long as they do not cause me pain.

1 of 4 Principal _____

I hope my family and friends would consider that...

(a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.

(b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.

(c) Please don't be afraid to hold my hand or hug me.

(d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me.

(e) Please maintain a cheerful atmosphere around me.

(f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.

(g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.

(h) If at all possible, allow me to die in my home.

(i) Please arrange for me to watch television or listen to my favorite sports events.

(j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.

(k) I want to have my favorite types of music played when possible.

(l) I want to have religious readings read to me when I am near death.

(m) I want to have my favorite poems read to me from time to time.

I want you to know the following about my thoughts and concerns, if I am disabled and cannot convey these thoughts to you verbally...

- (1) I want you to know that I love you.
- (2) I would like to be forgiven for the times I have hurt you.
- (3) I forgive you for what you may have done to me in my life.
- (4) I want you to know that I do not fear death itself.
- (5) I want all of my family members to recommit their love for one another.
- (6) Please remember me the way I was before I had a terminal illness.
- (7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all.
- (8) Don't be afraid to seek counseling, if you have trouble with my death.

If friends want to know how I want to be remembered, tell them the following...

The following person(s) know my funeral plans...

At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...

I also have the following requests...

In Process

These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Dated this ____ day of _____, 20____.

Signature _____

Print Name EXAMPLE

4 of 4 Principal _____

In Process