DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Health Care Advance Directive

For

Washington State Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Health Care Advance Directive

For

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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Health Care Advance Directive
For Washington State Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes,*
and to have these wishes followed ~~

The Washington state legislature has designed a Living Will for use by the public, and provided statutes guiding the construction of a Power of Attorney for Health Care. As these documents were designed/structured by your state government, each is in full compliance with all applicable laws, statutes, and ordinances. There is an introduction that summarizes the scope and purpose of the document, as well as providing directions for its completion. Read it carefully to ensure that your Advance Directive is fully and properly filled out.

By completing these documents, you can have the peace of mind that your wishes can be known and followed. It is also a meaningful gift to those you love, who will have to make fewer difficult choices for you without an understanding of what you would want done.

***Understanding Your Directive*:**

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to speak due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want, if you cannot speak for yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid.

You can **limit** your directive and the authority of anyone named in it, but *only at the time of first completion*. Any scope-of-authority changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them.

Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete the document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:

LIVING WILL DIRECTIVE

and Additional Personal Instructions

(RCW §70.122.01 to §70.122.920)

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1. INTRODUCTION: *The Washington State Living Will was designed primarily to assist those wishing to refuse life-sustaining treatment in a terminal condition, or permanently unconscious condition (§70.122.030).*

*A **terminal condition** is defined as, "an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient"(§70.122.020).*

*A **permanent unconscious condition** is defined as "an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state"(§70.122.020).*

***Life-sustaining treatment** is defined as, "any medical or surgical intervention that uses mechanical or other artificial mens, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which...would serve only to prolong the process of dying." It is specifically noted that such treatment does not include "the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain"(§70.122.020).*

Intent to Complete a Living Will

2. I choose *not* to complete a Living Will at this time, but I *do* wish to complete a Health Care Power of Attorney (*sign here and skip forward to page 6*):

   Signature: _____ Date: _____

   OR:

3. I, _____, being of sound mind, and acting willingly and without duress, fraud or undue influence, herein direct that the instructions provided in Section I of this document represent my Living Will and health care treatment wishes. It is my intent that these instructions be used to guide to any agent, attorney-in-fact, proxy, representative, court-appointed guardian or conservator, medical professional, or family member, as well as any other person or entity providing or overseeing my care, or making medical decisions in my behalf. These instructions shall be binding upon all involved to the fullest extent allowed by law.

HEALTH CARE DIRECTIVE

4. Directive made this _____ day of _____ 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, 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 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.

   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 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 a terminal condition or in a permanent unconscious condition: (*initial only <u>one</u>*)

_____ 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.

(h) I also wish to add the following further instructions: _____

_____

_____

_____

_____

_____

_____

Signature of Principal

5. Signed: _____

Date: _____

Residence: _____

City/County/State: _____

Statement of Witnesses

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

7. Witness: _____

   Printed Name:_____

   Address: _____

8. Witness: _____

   Printed Name:_____

   Address: _____

SECTION II:
DURABLE POWER OF ATTORNEY

Designation of Health Care Agent and Instructions

(RCW Title 11: Ch.11.94, §11.94.010 to §11.94.900)

9. INTRODUCTION: *Washington power of attorney statutes specifically allow you to name person to make health care decisions for you, if you cannot make them for yourself (§11.94.010(3)(a)). The person you name must be at least 18 years of age. The powers granted through this document include the power to make health care decisions, as well as authorities regarding related affairs. If you have questions, you should seek legal advice.*

10. ***Be it known that I***:

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ Intend by this document to create a durable power of attorney for health care. This power of attorney shall not be affected by my later disability, incompetency, or incapacity (as the "principal" herein). I am of sound mind, and state that execution of this document is voluntary and without duress. Creation of this power of attorney is for the purpose of designating someone to act as my health care agent (also known as my attorney-in-fact), to act in my place to make medical decisions for me if I become unable to make them for myself . It also grants my agent the authority to make other legal and personal care decisions as outlined in this document. This designation is effective when, in the opinion of two licensed medical doctors who have personally examined me, I am no longer able make personal medical treatment decisions for myself. By creating this document I revoke any prior power of attorney for health care.

11. I understand that I am <u>not</u> required to choose an agent, but that I am advised to do so to ensure that my wishes are fully represented and followed. Therefore:

(*initial only <u>one</u>*)

_____ I do <u>not</u> want to choose a health care agent at this time (*or I have no one appropriate to the task*). However, I instruct that Section I of this document be recognized (by statutory law, common law, and/or federal law) as a declaration of my wishes within this Advance Directive (*proceed to sign on page 8*);

OR,

_____ I <u>do</u> wish to appoint a health care agent. I recognize that, by Washington state law, this person may ***<u>not</u>*** be my health care provider nor an employer of my health care provider, nor an owner, administrator, or employee of a health care facility or long-term care facility. The person I have chosen to act as my agent and to whom I give **full** authority to make all medical and health care decisions for me at any time during which I am unable to make them for myself, is:

12. **Name of Agent**: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

13. If for any reason I revoke the authority of my agent, or this individual is unavailable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternate proxies:

14. **Name of Alternate #1:**_____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

15. **Name of Alternate #2:** _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

16. Each alternate successor designated shall be vested with the same power and duties as if originally named as my health care agent. These persons, *in priority of the order presented*, are to have binding authority over any and all other persons to make my personal and health care decisions. In making decisions in my behalf *if my wishes are not clear*, I direct my agent to act in his/her best understanding of what my wishes would have been. And, where not reasonably sure of what I would have wanted, to act according to his/her belief in my interests as determined from his/her knowledge of my personal and family affairs, and other goals and values in life. The authority of my agent shall not be terminated <u>*unless*</u> it appears that he or she is clearly and obviously not acting in accordance with my known wishes, or is overwhelmingly ignoring my best interests if my wishes are not otherwise known.

***Specific Agent Authority and General Intent*:**

17. My agent shall have the same authority to make health care decisions for me as I would if I had the capacity to make them myself, subject to any limitations imposed through this document. Below are listed further specific authorities given to my agent as named in this document:

A. I authorize my health care agent to make decisions in my best interest concerning withdrawal or withholding of health care, *including but not limited to the provision of artificial nutrition and hydration*. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial,

or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, *even if death may result*. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

B. Consent, refuse consent, renew or withdraw consent to any treatment, tests, medications, care, services, surgery or therapies used to diagnose or treat any physical or mental condition.

C. To employ or contract with medical and personal care providers necessary for my health care.

D. To admit and discharge me from any hospital or other health care facility.

E. To request, review, receive, and disclose any medical information, verbal or written, needed to follow and manage my physical or mental health treatment and general care, and to authorize the release of my medical records or any other documentation needed to continue my treatment in or outside of any health care setting or service. This release authority applies to any information governed by the *Health Insurance Portability and Accountability Act of 1996 (HIPPA), 42 U.S.C. 1320d and 45 CFR 160 through 164*.

F. To make anatomical gifts on my behalf.

G. To authorize autopsy, if desired by my physicians or by my agent.

Additional Agent Instructions:

18. I also wish to add the following instructions to my agent: _____

_____

_____

_____

_____

Statement and Signature of Principal/grantor:

19. This document is governed by Indiana law, although I request that it be honored in any state in which I may be found.

By signing below, I indicate that I am fully aware of the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

20. Signed:_____ Date: _____

At: (City) _____ (State) _____

Statement of Witnesses

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

22. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

23. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:

24. In Washington State,

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence* (describe:_____)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**
Signature of Notary Public

_____
Date Commission Expires

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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