

## ADVANCE DIRECTIVE: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This advance directive, a durable power of attorney for health care, allows you to name your health care agent. This form meets the requirements of Washington state law.

### My Information:

FULL NAME: \_\_\_\_\_ PRONOUNS (optional): \_\_\_\_\_  
 (i.e., he/she/they)

DATE OF BIRTH:     /     /     \_\_\_\_\_  
 (mm/dd/yyyy)

## NAMING A HEALTH CARE AGENT

### The person I designate as my health care agent is:

FULL NAME: \_\_\_\_\_ PRONOUNS (optional): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ BEST PHONE: (     )     ALTERNATE PHONE: (     )

ADDRESS, CITY, STATE, ZIP: \_\_\_\_\_

### The people I designate as my alternate agents are:

If the person listed above is unable or unwilling to make my health care decisions, then I designate the people listed below as my first and second alternate health care agents.

#### First Alternate

FULL NAME: \_\_\_\_\_ PRONOUNS (optional): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ BEST PHONE: (     )     ALTERNATE PHONE: (     )

ADDRESS, CITY, STATE, ZIP: \_\_\_\_\_

#### Second Alternate

FULL NAME: \_\_\_\_\_ PRONOUNS (optional): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ BEST PHONE: (     )     ALTERNATE PHONE: (     )

ADDRESS, CITY, STATE, ZIP: \_\_\_\_\_

*Initial below if this situation applies to you. You may draw a line through statement if it does not apply to you.  
 For more information: see the ACP Overview.*

\_\_\_\_\_ If I name my spouse or registered domestic partner as my health care agent and we later file for a dissolution, annulment, or legal separation; I want them to continue as my health care agent.



## Guidance for my healthcare agent

Write information you want your health care agent to know about your health care wishes.

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## AUTHORIZING A HEALTH CARE AGENT

**Statement of General Authority and Powers of My Health Care Agent:** I authorize my health care agent to give consent for medical treatments when I cannot make my own decisions. I authorize my health care agent to carry out my wishes regarding life-support treatments such as a CPR, breathing machines, feeding tubes, blood transfusions, and kidney dialysis. This includes consent to start, continue, or stop medical treatment.

**I attest to the following:** I understand the importance and meaning of this durable power of attorney for health care (DPOA-HC). This form reflects my health care agent choices. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can revoke and replace this form at any time. I revoke any prior durable power of attorney for health care. I want this DPOA-HC to become effective if a physician or licensed psychologist determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

MY SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS, CITY, STATE, ZIP: \_\_\_\_\_

### Witnesses or Notary Requirement

You must have your signature either witnessed by two people or acknowledged by a notary public.

#### OPTION 1 – TWO WITNESSES

**Witness Attestation:** I declare I meet the rules for being a witness.

WITNESS #1 SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME PRINTED: \_\_\_\_\_

WITNESS #2 SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME PRINTED: \_\_\_\_\_

#### OPTION 2 – NOTARY

STATE OF WASHINGTON )  
 )  
 COUNTY OF \_\_\_\_\_ )

This record was acknowledged before me on this \_\_\_\_\_ day of \_\_\_\_\_,

by (name of individual): \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Exp: \_\_\_\_\_

**Rules for Witnesses:**

- Must be at least 18 years of age and competent.
- Cannot be related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Cannot be your designated health care agent.



NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (mm/dd/yyyy)