Advance Directive

Health Care Directive

What is a Health Care Directive?

A Health Care Directive is a legal document that tells your physician whether to stop life-sustaining treatments and allow a natural death if you have a terminal condition or are permanently unconscious and you cannot make medical decisions for yourself.

My Health Care Directive

This Health Care Directive is made this _____ day of _____(month/year).

I, _____, am able to make health care decisions. I deliberately and voluntarily declare the following. If I cannot make decisions for myself about the use of life-sustaining treatment, I want my health care agent, family and physicians to follow this directive. This is my final statement of my legal right to accept or refuse medical or surgical treatment. I accept the results of my decisions. If someone is appointed to make life-sustaining treatment decisions for me, I want that person to follow this directive and any other clear statements of my wishes.

Life-Sustaining Treatment

Life-sustaining treatment means a way to sustain, restore, or replace a vital function by different types of machines or devices, including artificial nutrition and hydration. For a patient with a permanent unconscious condition or terminal condition, life-sustaining treatment would only prolong the process of dying. Medicines or other treatments that are only used to ease pain *are not* considered life-sustaining treatments.

Terminal Condition

I understand that a terminal condition means a condition caused by an injury or sickness that a physician has judged cannot be cured or changed. The terminal condition would likely cause death within a short period of time. Life-sustaining treatment would only prolong my dying.

If my physician states in writing that I have a terminal condition and life-sustaining treatment would only prolong my dying, **(check one)**

☐ I DO want life-sustaining treatment.

☐ I DO NOT want life-sustaining treatment to be started. If it has been started, I want it to be stopped. I want to be allowed to die naturally.

Permanent Unconscious Condition

I understand that a permanent unconscious condition means an incurable and irreversible coma or a persistent vegetative state, and two physicians have judged there is little chance of recovery.

If two physicians state in writing that I am in a permanent unconscious condition, **(check one)**

☐ I DO want life-sustaining treatment.

☐ I DO NOT want life-sustaining treatment to be started. If it has been started, I want it to be stopped. I want to be allowed to die naturally.

Nutrition and Hydration

If I have a terminal condition or am in a permanent unconscious condition, I want my health care providers and health care agent to do the following **(check one for each)**:

Nutrition

- ☐ I DO want to have artificially provided nutrition.
- ☐ I DO NOT want to have artificially provided nutrition.

Hydration

- ☐ I DO want to have artificially provided hydration.
- ☐ I DO NOT want to have artificially provided hydration.

Pregnancy

If I am pregnant and my physician knows I am pregnant, I understand that this Health Care Directive will have no force or effect during my pregnancy.

Additional Directions

If I have a terminal condition or am in a permanent unconscious condition, I want my physicians, health care agent, or others to follow these additional directions about my health care treatment.

_____

_____

Signature

I understand the importance and meaning of this directive and my decisions. I am emotionally and mentally able to make the health care decisions in this directive. I understand that before I sign this directive, I can add to, delete from, or change the wording of this directive. I also understand that I may revoke and update this directive at any time. I want every part of this directive to be followed. If for any reason any part of my directive cannot be followed, I want the remainder of my directive to be followed.

I understand that two witnesses must watch me sign this form.

My Signature: _____

My Name (printed): _____

Address: _____

City/County/State/ZIP: _____

Witnesses or Notary Requirement

Washington residents must have their signature on the Health Care Directive form **either** witnessed by two people **or** acknowledged by a notary public.

Please note: The health care directive witness requirements differ from the DPOAH witness requirements.

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Name: _____

Date of Birth: _____

Health Care Directive

Option 1 – Two Witnesses

Rules for Witnesses:

- Must be at least 18 years of age and competent.
- Must watch you sign this form.
- Cannot be related to you by blood or marriage.
- Would not be entitled to any portion of your estate upon your death.
- Cannot be your attending physician or an employee of your attending physician or health care facility where you are a patient.
- Cannot be any person who has claim against any portion of your estate at the time of signature of this document.

Attestation: The declarer has been personally known to me or has provided proof of identity. I believe him or her to be capable of making health care decisions.

Witness #1

Signature: _____

Date: _____

Name (printed): _____

Address: _____

City, County, State, ZIP: _____

Witness #2

Signature: _____

Date: _____

Name (printed): _____

Address: _____

City, County, State, ZIP: _____

Option 2 – Notary

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this _____ day of _____, _____

by _____.
(Name of individual)

_____
(Signature of notary public)

_____
(Title of office)

My commission expires: _____.

This ends the Health Care Directive.

Name: _____

Date of Birth: _____