

## Washington State Health Care Directive (Living Will)

This package contains a Health Care Directive (sometimes known as a Living Will) for the State of Washington.

These forms are not intended and are not a substitute for legal advice. Laws vary from time to time and from state to state. These forms should only be a starting point for you and should not be used without consulting with an attorney first. Before using or signing this document you should have an attorney review it to make sure it fits your particular situation. You should also consult an attorney whenever a document is negotiated with another party.

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# **Notice To**

## **Person Executing the Washington State Health Care Directive**

This is an important legal document. Before executing this document you should know these facts:

This document becomes effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.

Think about whether or not you want life-sustaining treatment should you become terminally ill if such treatment would only prolong the process of dying.

If you do not want such treatment used, carefully read the Health Care Directive document to ensure you agree with it.

This document also provides the option of also consenting to withholding and withdrawal of artificial hydration and nutrition by inserting your initials in the box provided.

You must be 18 years of age or older to sign the Directive. You must sign the document in the presence of two witnesses.

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.

The original signed and witnessed copy should be kept by a designated person or in a designated place of safe keeping where they can be obtained in any emergency situation. 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

# Health Care Directive

Directive made this \_\_\_\_\_ day of \_\_\_\_\_ (month, year).

I, \_\_\_\_\_, being of sound mind and 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:

If at any time I should be diagnosed or certified 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 "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 **do** /  I **do not** [*check one*] want to have artificially provided nutrition and hydration. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.

I **do** /  I **do not** [*check one*] want either cardiopulmonary resuscitation (manual or mechanical efforts to restore heartbeat or breathing after they have stopped) or assisted ventilation (use of a respirator to help keep a person breathing)

I **do** /  I **do not** [*check one*] want tube feeding (use of a tube through the nose or abdomen for feeding a person who can't take food by mouth)

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) and other health care providers 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. I accept the consequences of such refusal.

*(Only applicable to females)* 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

I understand the full import of this directive and I am emotionally and mentally capable and competent to make the health care decisions contained in this directive. I also understand that I may amend or revoke this directive at any time.

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.

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.

In addition I make the following additional directions regarding my care (if none, write "none"):

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Signed at \_\_\_\_\_, Washington, on \_\_\_\_\_ (date)

Signature \_\_\_\_\_

Printed name: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number or Birthdate \_\_\_\_\_

### Statement of Witnesses

The declarer has been personally known to me and I believe to be capable of making health care decisions. In addition, 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.

Signature of witness 1:

Signature of witness 2:

\_\_\_\_\_  
Print name here:

\_\_\_\_\_  
Print name here:

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Address:

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