DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This advance directive, the Durable Power of Attorney for Health Care, allows you to name the person who makes health care decisions for you when you are unable to make them for yourself. This person is the Health Care Agent. This form meets the requirements of Washington state law.

My information:

Full Name: Medical Record Number:

Date of Birth: / /

(mm/dd/yyyy)

MY HEALTH CARE AGENTS

The person I designate as my Health Care Agent is:

Full Name: Date of Birth: / /

Address, City, State, ZIP: Phone:

In the event that the person listed above is unable or unwilling to serve, or is unable to be contacted with reasonable effort, then I grant these powers to the next qualifying Health Care Agent listed below:

First Alternate

Full Name: Date of Birth: / /

Address, City, State, ZIP: Phone:

Second Alternate

Full Name: Date of Birth: / /

Address, City, State, ZIP: Phone:

AUTHORIZING A HEALTH CARE AGENT

Statement of General Authority and Powers of My Health Care Agent: My Health Care Agent is specifically authorized to give consent for health care treatment when I cannot make my own decisions. My Health Care Agent is authorized to carry out my wishes regarding life-sustaining treatments such as feeding tube, CPR, breathing machine, and kidney dialysis. This includes consent to start, continue, or stop medical treatment. This document gives the person you designate as your Health Care Agent the power to make health care decisions for you and is 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. Your wishes for medical treatment can be attached to this form. You may include specific limitations in this document on the Health Care Agent's authority to make health care decisions if you choose.

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 choices for Health Care Agent. 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 replace this form at any time which will then revoke any prior DPOA-HC. I want this DPOA-HC to become

Full Name: Medical Record Number:

Date of Birth: / /

effective if a physician or designee of my choosing determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

Two witnesses OR a notary must watch me sign this form for it to be legally valid.

My Signature: **Date:**

WITNESSES OR NOTARY REQUIREMENT

Without witness signatures or notarization, this form is not legally valid.

Option 1: Two Witnesses

Witness Requirements:

- 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.

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: