HEALTH CARE DIRECTIVE (LIVING WILL)

Full Name: Medical Record Number:

Date of Birth: / /

Directive made this _____ day of _____,_____ .
(Year)

I, _____ being of sound mind, 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 have an incurable and irreversible condition certified to be a terminal condition by my attending physician, 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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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.

(B) If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.
(C) If I am diagnosed to be in a terminal or permanent unconscious condition, [choose one]

☐ I DO want artificially administered nutrition and hydration.

☐ I DO NOT want artificially administered 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.

(D) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians, and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

(E) 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.

(F) I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.

(G) I make the following additional directions regarding my care:

_____

My Signature *and* ***Notary*** *or* ***Two Witness Signatures*** *required on next page*

Full Name: Medical Record Number:

Date of Birth: / /

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

My Signature:

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.
- Cannot be any person who has a claim against any portion of the estate of the declarer upon the declarer's decease at the time of the execution of the directive.

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: