Washington Living Will

Rev. Code Wash. (ARCW) § 70.122.030

Directive made this _____ day of _____ (month, year).

I _____, 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:

(a) If at any time I should be diagnosed 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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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 by using this form that a 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 further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) 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) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of 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.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

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

(d) 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.

(e) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(f) 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.

(g) 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.

Signed _____

_____
City, County, and State of Residence

The declarer has been personally known to me and I believe him or her to be capable of making health care decisions.

Witness _____

Witness _____

Washington Durable Power of Attorney for Healthcare

I understand that my wishes as expressed in my living will may not cover all possible aspects of my care if I become incapacitated. Consequently, there may be a need for someone to accept or refuse medical intervention on my behalf, in consultation with my physician.

Therefore, I, _____, as principal, designate and appoint the person(s) listed below as my attorney-in-fact for healthcare decisions.

First Choice:
Name :_____
Address:_____
City/State/Zip Code: _____
Telephone Number: _____

If the above person is unable, unavailable, or unwilling to serve, I designate:

Second Choice:
Name :_____
Address:_____
City/State/Zip Code: _____
Telephone Number: _____

1. This Power of Attorney shall take effect upon my incapacity to make my own healthcare decisions, as determined by my treating physician and one other physician, and shall continue as long as the incapacity lasts or until I revoke it, whichever happens first.

2. The powers of my attorney-in-fact under this Power of Attorney are limited to making decision s a bout my healthcare on my behalf. These powers shall include the power to order the withholding or withdrawal of life-sustaining treatment if my attorney-in-fact believes, in his or her own judgment, that is what I would want if I could make the decision myself. The existence of this Durable Power of Attorney for Healthcare shall have no effect upon the validity of any other Power of Attorney for other purposes that I have executed or may execute in the future.

3. In the event that a proceeding is initiated to appoint a guardian of my person under *RCW 11.88*, I nominate the person designated as my first choice (on page 1) to serve as my guardian. My second choice will serve as my guardian if the first person is unable or unwilling.

4. I make the following additional instructions regarding my care:

By signing this document, I indicate that I understand the purpose and effect of this Durable Power of Attorney for Healthcare.

Dated this _____ day of _____, 20_____.
(date) *(month)* *(year)*

Signed: _____

The person named as principal in this document is personally known to me. I believe that he/she is of sound mind, and that he/she signed this document freely and voluntarily.

Witness: _____

Witness: _____

HALT AN ORGANIZATION OF AMERICANS FOR LEGAL REFORM
Email: HALT@HALT.org http://www.HALT.org
Phone: 1-888-FOR-HALT (202) 887-8255
1612 K Street, NW Suite 510, Washington, DC 20006