My Name _____

My Date of Birth _____ My Medical Record #_____

HEALTH CARE DIRECTIVE (LIVING WILL)

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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.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.

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

My Name _____

My Date of Birth _____ My Medical Record #_____

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

Signed:* _____

*I understand that **two witnesses** OR **a notary** must watch me sign this form for it to be legally valid.

- **Option 1—Two witness signatures**

  The declarer has been personally known to me and I believe him or her to be of sound mind. In addition, I am not related by blood or marriage, nor the attending physician, an employee of the attending physician or health care facility in which the declarer is a patient, or 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.

  DATED this _____day of _____, _____ .
  (Year)

  Witness signature:_____

  Witness signature:_____

- **Option 2—Notary**

  STATE OF WASHINGTON) _____)ss.

  (COUNTY OF _____)

  I certify that I know or have satisfactory evidence that the GRANTOR,_____ signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

  DATED this _____day of _____, _____ .
  (Year)

  _____

  NOTARY PUBLIC in and for the State of Washington,

  residing at _____

  My commission expires _____