SAMPLE
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HEALTH CARE DIRECTIVE

Form No. 127 with overview and instructions

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HEALTH CARE DIRECTIVE

I, ____, Declarant, 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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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.
☐ I DO NOT want to have artificially provided nutrition.

(d) 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 hydration.
☐ I DO NOT want to have artificially provided hydration.

(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 capable to make the health care decisions contained in this Directive.

(g) 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.

(h) ______ (initial) By this Directive I do not mean to preclude the use of pain medication or other treatment to make me comfortable or alleviate pain.

(i) (Other directions) ____
____
____
____
____

(j) 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.

DATED ______________________________.

____
DECLARANT SIGNATURE

____
TYPE OR PRINT NAME

____
ADDRESS

____
CITY STATE ZIP

(OVER)

SAMPLE

STATE OF WASHINGTON, } ss.

County of ____________________________________

I hereby witness this Directive and attest that:

(1) This Directive was signed by the Declarant in the presence of the other witness and me.

(2) To the best of my knowledge, at the time of execution of this Directive:

(a) I am over the age of eighteen (18) years;

(b) I am not related to the Declarant by blood or marriage;

(c) I am not entitled to any portion of the estate upon the Declarant's death under any will of the Declarant or codicil presently existing or, at the time of the Directive, by operation of law then existing;

(d) I am not an attending physician, an employee of the attending physician or a health facility in which the declarant is a patient;

(e) I do not have any claim against any portion of the estate of the Declarant.

(3) I understand that if I have not witnessed this Directive in good faith, I may be responsible for any damages that arise out of giving this Directive its intended effect.

(4) The Declarant is personally known to me and I believe him or her to be capable of making health care decisions.

______________________________ WITNESS SIGNATURE	______________________________ WITNESS SIGNATURE
______________________________ WITNESS NAME (TYPED OR PRINTED)	______________________________ WITNESS NAME (TYPED OR PRINTED)
______________________________ ADDRESS	______________________________ ADDRESS
______________________________ CITY STATE ZIP	______________________________ CITY STATE ZIP

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

DATED ________________________________.

____

Notary Public for Washington

My appointment expires ______________________

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