end of life
WASHINGTON
Your life. Your death. Your choice.

INSTRUCTIONS FOR THE END OF LIFE WASHINGTON ADVANCE DIRECTIVE

The instructions contained in this document will enable you to complete and implement your End of Life Washington Advance Directive. The End of Life Washington Advance Directive combines two legal documents to protect your right to refuse medical treatment you do not want or to request treatment you do want, in the event you lose the ability to make decisions. Combining two documents into one makes it less likely that one or the other will be misplaced.

1. The **Durable Power of Attorney for Health Care** (DPOAHC) lets you name someone, called a health care agent, to make decisions about your medical care, including decisions about life support, if you can no longer speak for yourself.

2. The **Health Care Directive** lets you state your wishes about medical care in the event your attending physician determines that you have developed a terminal or hopeless condition and can no longer make your own medical decisions. The Health Care Directive also applies to conditions of persistent unconsciousness, irreversible coma, and persistent vegetative state. Another doctor must then agree with your attending physician's opinion.

The End of Life Washington Advance Directive was created to comply with Washington State law. It may not be honored in all states. For more detailed information about the DPOAHC and the Health Care Directive, request our *About Advance Directives* information sheet.

PREPARING YOUR END OF LIFE WASHINGTON ADVANCE DIRECTIVE

- Consider filling out the Values Worksheet to help you gather your thoughts and clarify your values about end-of-life choices. If you feel it helps explain your beliefs about your end-of-life wishes, you can attach it to your advance directive. Or, you can create your own values statement that speaks to a specific scenario of concern to you.

- Read the instructions in their entirety before completing your advance directive.
- Photocopy the advance directive before you start so that you have an original if you need to start over.
- Talk with your family, friends, and physicians about your decision to complete an advance directive.
- Be sure the person you appoint as your health care agent understands your wishes and agrees to honor them.
- This is your document. When completed, it should express your wishes. Cross out sections or words with which you don't agree.

The numbers below correspond to the sections on your End of Life Washington Advance Directive form.

1. WHEN I WANT THIS DOCUMENT TO APPLY

Washington law does not explicitly allow health care directives to remain in effect after death. This section states your intention that the document remain in effect to carry out any procedure you request or consent to in section 10.

2. MY HEALTH CARE AGENT

The person you name to be your health care agent:

- Must be at least 18 years old and mentally competent.
- May be a family member or close friend whom you trust to make serious decisions.
- Should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.
- Should be someone who can be assertive in the event that caregivers, family members, or health care providers challenge your wishes.
- Does not have to be your spouse, partner, or a member of your biological family.
- Need not live in Washington but would need to be readily available in a medical emergency.

The person you appoint as your health care agent cannot be:

- Your doctor or an employee of your doctor.
- An owner, operator, administrator, or employee of a health care facility in which you are a patient at the time you sign your advance directive.

However, if one of the individuals listed above (your doctor, an employee of your doctor, etc.) is also your spouse, adult child, or sibling, you may appoint that individual to be your health care agent. In the event that your agent is unable to make decisions on your behalf, you may also name an alternate agent.

Designating a health care agent is highly recommended. For assistance with finding one, call End of Life Washington. If you do not designate a health care agent, Washington State law authorizes the following people, in order of priority, to make health care decisions for you. When there is more than one person given authority, such as your children, parents, or siblings, all must agree.

- A guardian with health decision-making authority, if one has been appointed by a court.
- Your spouse or registered domestic partner.
- Your adult children.
- Your parents.
- Your adult siblings.

If you choose not to name a health care agent in section 2, cross out section 2 and 3 and go on to section 4.

Note to same-sex spouses and registered domestic partners: If you do not designate your same-sex spouse or your registered domestic partner as your health care agent, your spouse's or partner's right to make health care decisions for you may be challenged outside of Washington. Your spouse or partner could also be denied access to you in an emergency medical situation.

3. THE AUTHORITY I GIVE MY AGENT

A statement in this section refers to the *Physician Orders for Life-Sustaining Treatment* (POLST) form, a relatively new form requiring a physician's signature to be valid. The POLST form is intended for any adult, 18 years of age or older, with serious health conditions. The form translates your wishes regarding life-sustaining treatments into a physician's orders. While the POLST program specifically permits your health care agent to fill out a POLST form for you, some physicians may be reluctant to sign when someone other than the patient is requesting it. Granting specific authority to your health care agent to complete a POLST form on your behalf may alleviate a physician's concern.

4. HOW TO MAKE HEALTH CARE DECISIONS FOR ME

This section is especially important when no health care agent is named in section 2. For those who do name a health care agent, it provides guidance if a situation not covered by the End of Life Washington Advance Directive should occur

5. WHY I AM MAKING THIS DOCUMENT

This section allows you to attach an additional statement that describes and reinforces values expressed in your document. However, no additional statement to section 5 is necessary or required. You may want to write in more specific terms what you want your dying to be like. This statement might include relevant medical history involving you or close family and friends and deeply held religious, spiritual, and philosophical beliefs. If you feel that certain family members will not honor your wishes or challenge decisions by your health care agent(s), you may include information here directing physicians and the courts to disregard his or her demands. If you are a younger, nonterminally ill adult who wants to refuse all forms of life-sustaining treatment because your current medical condition is causing you to experience an unacceptable quality of life, you should explain this here.

6. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

a. Qualities of life I consider worse than death:

(1) Unconsciousness or coma from which the ability to think and communicate: Heart attack, stroke, head injury, drug overdose, and other conditions can all result in unconsciousness that may later be diagnosed as chronic coma or persistent vegetative state (PVS). A majority of comatose adults who do not show clear signs of recovery within a few weeks (usually between two and four) are unlikely to recover; most will either die or enter a PVS.

This provision is included to help avoid a situation in which life-sustaining treatment during coma or PVS is continued indefinitely because a physician remains uncertain of the prognosis. In light of your own values, you may want to limit the length of time life-sustaining treatment would be used in such a circumstance. If you prefer to rely on a physician's judgment, write "Dr's judgment" in the "insert number" space.

(6) Other circumstances in which I would not want life-sustaining treatment: Your experience may enable you to identify circumstances, in addition to or instead of those in a.(1) through a.(5) that would mean an unacceptable quality of life for you. You may use this space to state, in your own words, any outcomes or conditions you consider "worse than death." People with potentially life-threatening, chronic conditions are encouraged to discuss with their physicians any specific instructions relating to their conditions that they want to include here.

This section is optional. If this space is not sufficient, write: "See attached page." Any attached page should be signed, witnessed, and notarized just as at the end of this document.

b. Temporary use of life-sustaining treatment

Sometimes it is hard for physicians to know if using life-sustaining treatment for a short period of time will enable a patient to recover. Some people want their physician to try such treatments if there is a good chance of recovery. Others would not want life-sustaining treatment begun, because they fear once treatment has started it might be difficult to get it stopped.

If you want temporary use of life-sustaining treatment when your physician believes it would restore an acceptable quality of life, you can place an approximate time limit on such attempts. It can be very difficult for physicians and health care agents to give up trying when they know it means a patient will soon die. Stating a time limit will give them permission to stop treatment when there is no reasonable expectation of recovery. If you prefer to rely on a physician's judgment, write "Dr's judgment" in the space.

This time limit for temporary treatment is not the same as the time limit you may include in a.(1) above. In a.(1) the issue is uncertainty whether an unconscious patient will ever regain consciousness. This section applies only to situations where a physician believes that life-sustaining treatment for a short period will restore acceptable
quality of life.

7. LIFE-SUSTAINING TREATMENTS I DO NOT WANT

Physicians may be reluctant to forgo life-sustaining treatment they believe will keep a patient alive, unless they know a patient has indicated his or her wishes. This section identifies life-sustaining procedures you would not want started or continued. Initial any treatments you do not want. Treatments you do not initial might be used, but this does not mean they will be used. Patients or their families have no legal right to require treatments that, according to their physicians, are of no medical value to the patient.

8. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION

This section has been added because some health care providers do not do a good job managing pain. The administration of high levels of pain medication can decrease breathing to the point of hastening death. Decreased breathing in such circumstances does not cause suffering because the medication produces heavy sedation. Drug dependency in a dying person (whose condition warrants high levels of medication to control pain) is neither an ethical or legal concern. Developing a tolerance to pain medication is not addiction. Do not leave this section blank; initial yes or no.

9. REGARDING A HEALTH CARE INSTITUTION REFUSING TO HONOR MY WISHES

Catholic or other religiously affiliated health care providers adhere to certain religious directives or moral teachings and may not honor your advance directive if it conflicts with their institutional values. If you are terminally ill or death is imminent, religiously affiliated providers will usually honor your choices to stop or not start life-sustaining treatment. However, in situations involving pregnancy or persistent vegetative state, they may decline to honor your wishes. Moving to a different facility is sometimes the best option.

10. MY WISHES CONCERNING OTHER MATTERS

Do not leave any of these blank; initial yes or no:

a. I consent to medical treatments that are experimental.
A physician might offer a new test or procedure that could be beneficial, even though its effectiveness or risks are not well-known.

b. I want to donate organs/tissues.
Your wish to be an organ donor can also be indicated on your driver's license and/or by completing an organ donor card. Because Washington law does not explicitly give health care agents priority in consenting to organ or tissues donation, it is important that everyone in your immediate family knows about and supports your wishes.

c. I consent to an autops*y.*
After death, physicians sometimes want to do autopsies to obtain information about an injury or disease process that could help them treat other patients.

d. I consent to use of all or part of my body for medical education or research*.*
If you wish your body to go to a specific medical or research institution, you should make prior arrangements with that institution and with your physician (in addition to initialing YES).

e. I have named the following individual(s) as my designated agent(s) for funeral arrangements:
In 2011, Washington passed a law allowing individuals to name a designated agent to direct funeral arrangements in accordance with your wishes. Naming a designated agent or an alternate agent is not required. <u>If you do not use this section, cross it out</u>. If you have a designated agent, but no alternate, cross out the alternate agent section.

f. I want my remains to be disposed of as follows:
Often people have particular ideas about what they want (or do not want) done with their bodies after death. You must still make the necessary arrangements so that your instructions can be carried out. If you have left instructions in a property will or have made arrangements with a funeral home or People's Memorial Association, there is no need to complete this part. If you do not use this section, cross it out.

11. IF A COURT APPOINTS A GUARDIAN FOR ME

Unlike many states, Washington law does not direct that a health care agent should be the court's first choice for guardian. It makes sense to request that one of your health care agents serve as your guardian, if such an appointment becomes necessary, because that is the person you trust who could make a decision to end your life. A judge is not required to appoint the person you request, but the court would probably give your wishes serious consideration.

12. HOW THIS DIRECTIVE CAN BE REVOKED OR CANCELED

You may revoke your End of Life Washington Advance Directive at any time by doing any one of the following:

- Canceling, defacing, obliterating, burning, tearing, or otherwise physically destroying it or having another person destroy it for you in your presence. All copies should be destroyed.
- Executing a written and dated revocation.
- Orally expressing your intent to revoke it.

If you revoke your advance directive, you should notify your health care agent and your health care provider(s) in writing of your intent to revoke. If you are unable to write, you can have someone else write a statement for you explaining that you are unable to write, but want your advance directive revoked.

While Washington law does not permit an incompetent person to execute an advance directive, this is not true for revocation. Incapacity to make decisions sometimes cannot be clearly determined for a very ill patient who can still communicate; this makes it hard to decide if a statement revoking an advance directive is an authentic expression of intent. Therefore, the law allows an incompetent person to revoke his or her advance directive. This section clarifies that statements or actions by you expressing disagreement with a particular decision made by your health care agent does not constitute revocation.

13. SUMMARY AND SIGNATURE

Do not sign and date your form until you are in the presence of valid witnesses and – if you are having your document notarized (see below) – a notary.

14. STATEMENT OF WITNESSES

In order to make your advance directive legally binding, you must sign the document in the presence of two adult witnesses (and a notary, if you elect to have your document notarized). The two witnesses cannot be:

- Related to you by blood or marriage.
- Entitled to any portion of your estate through the operation of law or through any will or codicil.
- A person who has a claim against your estate.
- Your attending physician or an employee of your attending physician.
- An owner, operator, administrator, or employee of a health care facility in which you are a patient at the time you sign your advance directive.

Make sure your witnesses meet the criteria for being a witness.

About Notarization: Notaries do not normally affirm anything beyond the identity of the person signing the document before them. While Washington State does not require notarization of this advance directive to make it legal, this form includes a notary statement because we believe that notarization eliminates doubt about the validity of your document in the future. Additionally, some states do require advance directives to be notarized. Notaries can be found at your bank, insurance office, or some office supply stores (call ahead to make sure they will be present). End of Life Washington provides complimentary notarization of advance directives in our Seattle office.

If you have questions or need guidance in preparing your End of Life Washington Advance Directive, please call our office at 206.256.1636 or 877.222.2816 toll-free, and a staff member will be glad to assist you.

AFTER COMPLETING YOUR END OF LIFE WASHINGTON ADVANCE DIRECTIVE

1. **Where to keep your Advance Directive**: Your advance directive is an important legal document, but unlike most legal documents, copies are just as valid as the original. Keep the original signed documents in a secure but accessible place. Do not give the original documents to your attorney or put them in a safe deposit box or any other security box that would keep others from having access to them in the event of an emergency. Your health care agent(s) or other close family and friends should know exactly where to look for your document. Tip: To ensure documents are on hand, many married couples and registered domestic partners carry copies of their advance directives in the glove box of their vehicles or in a compartment in their suitcases.

2. **Who should have a copy?** Give photocopies of the signed originals to your health care agent(s), doctor(s), lawyer, family, close friends, clergy, designated agent(s) for funeral arrangements, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.

3. **Tell important people about your wishes**: The importance of discussing your documents with the important people involved cannot be overemphasized. Discuss your wishes concerning medical treatment with your health care agent(s), doctor(s), clergy, family, and friends often, particularly if your medical condition changes. Make clear to other family members that your health care agent(s) will have final authority to act on your behalf. For more advice about communicating your end-of-life wishes, request our *Talking To Your Family About Dying* information sheet.

4. **Will the doctor honor your wishes?** When you present your advance directive to your physician(s), ask if he or she will honor it. If not, find a physician who will. For more information about communicating your wishes to your physician(s), request our *Talking to Your Doctor About Dying* information sheet.

5. **If you are admitted to a health care facility or enrolled in a home-based health care program**: You may be offered other living will forms. Do not fill out such forms; give admissions staff a copy of your completed End of Life Washington Advance Directive. Most other forms are not as comprehensive or effective as the End of Life Washington Advance Directive and may be interpreted in a way that will conflict with it.

6. **Making changes**: If you want to make changes to your documents after they have been signed and witnessed, you should complete a new document. However, updating addresses or phone numbers is permissible. Updates should be initialed and dated.

7. **Keep your advance directive updated**: Be sure to review your advance directive occasionally to be sure it reflects your current preferences and values. Initial and date it whenever you review it.

8. **Revoking your Advance Directive**: If you revoke your advance directive as per section 12, make sure you notify your health care agent(s), family, and doctor(s). If possible, retrieve and destroy copies of your revoked document, or instruct those who have revoked copies to destroy them. Keep one copy of your revoked advance directive in your records with the word "REVOKED" written across the front. This shows how long you have thought about these issues and could help if it becomes necessary to rely on a new advance directive shortly after you prepared the document.

9. **Medical emergencies**: Be aware that your advance directive will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) and other life-sustaining treatments unless a valid Physician Orders for Life-Sustaining Treatment (POLST) form is present.

10. **Travel to other states**: If you travel, you may want to take copies of your advance directive with you, as other states may honor it. Although they may have specific requirements about notarization or witnessing, most states do not require a specific form or format.

end of life WASHINGTON

Your life. Your death. Your choice.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE OF:

_____

{Your name here.}

This document states my choices about use of life-sustaining medical treatment and comfort care. It is meant to inform and guide whoever will make health care decisions for me, if I become unable to communicate.

1. WHEN I WANT THIS DOCUMENT TO APPLY

I want this document to apply if I become unable to make my own health care decisions.

I understand that such inability may only be temporary, and if I become unable to make certain decisions, I may still be able to make others. When I can make my own health care decisions I want to do so.

Even when I cannot make my own health care decisions, I want my physician and my health care decision maker(s) to talk to me honestly about my condition and treatment, if they think I might understand.

I want this directive to remain in effect after my death for autopsy, organ donation, use of my body for medical research, and for my agent to arrange for the disposition of my remains, if I authorize that in section 10.

2. MY HEALTH CARE AGENT

I appoint as my agent:

Name _____

Address _____

Telephone _____

(day) (evening) (mobile)

My alternate agent {optional}:
If my agent is unable or unwilling to serve, or is unavailable, or if my agent is a spouse or partner from whom I am separated or divorced when decisions need to be made for me, then I name this alternate agent:

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

If my alternate agent acts for me because my first agent is unavailable, I intend that the alternate act only while my first agent is unavailable.

3. THE AUTHORITY I GIVE MY AGENT

I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physicians, including life-sustaining treatments; (b) requesting particular medical treatments; (c) accessing my medical records and information; (d) employing and dismissing health care providers; (e) changing my health care insurers; (f) making a Physician Orders for Life-Sustaining Treatment (POLST) form for me; and (g) removing me from any health care facility to another facility, a private home, or other place. This release authority additionally applies to information governed by the Health Insurance Portability and Accounting Act of 1996 as hereafter amended.

4. HOW TO MAKE HEALTH CARE DECISIONS FOR ME

I want whoever makes health care decisions for me to do as I would want in the circumstances, based on the choices I express in this document. If what I would want is not known, then I want decisions to be made in my best interest, based on (a) my values, (b) the contents of this document, and (c) medical information provided by my health care providers.

5. WHY I AM MAKING THIS DOCUMENT

I value life very much, but I believe that to be kept alive in certain circumstances is worse than death. I do not want others to substitute their choices for mine because they disagree with my choices or because they think their choices are in my best interest. I do not want my intentions to be rejected because someone thinks that if I had more information when I completed this document, or if I had known certain medical facts that developed later, I would change my mind.

_____ I have completed and attached an additional statement of my values. {Optional}

6. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

a. Qualities of life I consider worse than death, and in which I would want to be allowed to die: {initial all that apply}

____ (1) Unconsciousness or coma from which the ability to think or communicate will probably not be recovered, or, unconsciousness lasting_____week(s), whichever comes first. {Insert number or "Dr's judgment."}

____ (2) Apparently complete or nearly complete loss of ability to think and communicate, which is probably permanent.

____ (3) Total dependence on others for my care because of physical deterioration, which is probably permanent.

____ (4) Pain which probably cannot be eliminated, or can be eliminated only by sedating me so heavily that I cannot converse.

____ (5) Irreversible dementia such as Alzheimer's Disease.

____ (6) Other circumstances in which I would not want life-sustaining treatment: {Optional}

b. Temporary use of life-sustaining treatment: I understand it is possible that I might experience an unacceptable quality of life – as initialed above or determined by my agent – at a time when my physician might believe temporary use of life-sustaining treatment would probably restore a quality of life acceptable to me. If so, then: {initial one}

_____ (1) I want life-sustaining treatment, for up to _____ week(s). {Insert number or "Dr's judgment."}

_____ (2) I still do not want life-sustaining treatment.

7. LIFE-SUSTAINING TREATMENTS I DO NOT WANT

If I experience a condition I initialed in 6.a. or if I experience a quality of life my agent believes I would consider unacceptable, I do not want these life-sustaining treatments started, and, if already in use, I want them stopped (except for temporary use if I authorized that in 6.b.). {Initial all that you do not want.}

_____ Nutrition and hydration other than ordinary food and water delivered by mouth, if I cannot eat and drink enough to sustain myself.

_____ All cardiopulmonary resuscitation (CPR) measures to try to restart my heart or breathing, if those stop, including artificial ventilation, stimulants, diuretics, heart regulating drugs, or any other treatment for heart failure.

_____ Heart regulating drugs including electrolyte replacement, if my heartbeat becomes irregular.

_____ Surgeries to prolong my life.

_____ Blood dialysis or filtration to clean life-threatening substances from my blood, if my kidneys do not work normally.

_____ Transfusions of blood, plasma, blood products, or other fluids to replace lost or diseased blood.

_____ Medications, when their purpose is to prolong life rather than control pain (for example: antibiotics, chemotherapy, steroids, medicines to make my heart work, and insulin).

_____ Anything else intended to keep me alive.

8. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION

	Yes	No
If I appear to be in pain or experiencing symptoms such as breathlessness or I am otherwise uncomfortable, I want vigorous treatment to relieve my pain and symptoms and make me comfortable, even if my physicians or other medical providers believe this might unintentionally hasten my death, cause drug dependency, or make me unconscious.	____	____

9. REGARDING A HEALTH CARE INSTITUTION REFUSING TO HONOR MY WISHES

I understand that circumstances beyond my control may cause me to be admitted to a health care institution whose policy is to decline to follow advance directives that conflict with certain religious or other beliefs. If I am a patient in such a health care institution when this advance directive comes into effect, I direct that my consent to admission shall not constitute implied consent to procedures or courses of treatment mandated by religious or other policies of the institution, if those procedures or courses of treatment conflict with this advance directive. Furthermore, if the health care institution in which I am a patient declines to follow my wishes as set out in the advance directive, I direct that I be transferred in a timely manner to a hospital, nursing home, private home, hospice or other institution which will agree to honor the instructions set forth in this advance directive.

10. MY WISHES CONCERNING OTHER MATTERS

		YES	NO
a.	I consent to medical treatments that are experimental.	_____	____
b.	I want to donate organs/tissues.	_____	____
c.	I consent to an autopsy.	_____	____
d.	I consent to use of all or part of my body for medical education or research.	_____	____

e. I have named the following individual(s) as my designated agent(s) for funeral arrangements:

My designated agent:

Name

Address

Telephone (day) (evening) (mobile)

My alternate agent: {optional}
If my primary agent is unable or unwilling to serve, or is unavailable, or if my agent is a spouse or partner from whom I am separated or divorced when decisions need to be made for me, then I name this alternate agent:

Name

Address

Telephone (day) (evening) (mobile)

f. I want my remains to be disposed of as follows: {describe}

11. IF A COURT APPOINTS A GUARDIAN FOR ME

If I have named a health care agent, I want my agent to be my guardian. If he/she cannot serve, then I want my alternate agent to be my guardian, if I have named an alternate. If the court decides to appoint someone else, I ask that the court require the guardian to consult with my agent (or alternate) concerning all health care decisions that would require my consent if I were acting for myself.

12. HOW THIS DIRECTIVE CAN BE REVOKED OR CANCELED

This directive can be revoked by a written statement to that effect, or by any other expression of intention to revoke. However, if I express disagreement with a particular decision made for me, that disagreement alone is not a revocation of this document.

13. SUMMARY AND SIGNATURE

I understand what this document means. If I am ever unable to make my own health care decisions, I am directing whoever makes them for me to do as I have said here. This includes withholding and/or withdrawing life-sustaining medical treatment, which might result in my death occurring sooner than if everything medically possible were done. I make this document of my free will, and I believe I have the mental and emotional capacity to do so. I want this document to become effective even if I become incompetent or otherwise disabled.

_____ _____

Signature Date

{**Sign only in the presence of two witnesses** and a notary, if notarizing.}

14. STATEMENT OF WITNESSES

_____

{**Print your name** – not the names of your witnesses – on this line.}

is personally known to me, and I believe him/her to be of sound mind and to have completed this document voluntarily. I affirm I am at least 18 years old, not related to him/her by blood, marriage, or adoption, and not his/her health care agent named in this document. As far as I know I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care, and I am not an employee of his/her physician or a health care facility where the person making this document may reside.

WITNESS 1		**WITNESS 2**	
_____ Signature	_____ Date	_____ Signature	_____ Date
_____ Printed Name	_____ Phone	_____ Printed Name	_____ Phone
_____ Address		_____ Address	

NOTARIZATION {optional}

STATE OF WASHINGTON County of _____

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

Dated this _____ day of _____, 20 ____

_____

NOTARY PUBLIC in and for the State of Washington
Residing at _____

My commission expires _____