



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, refer to our About Advance Directives information sheet, located in the Document Library under Advance Directives on our website at www.endoflifewa.org.

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.

- 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.

Your Advance Directive takes effect if you are unable to make your own health care decisions. This may be due to unconsciousness, heavy pain medications or some form of dementia that renders you unable to make rational decisions. Remember: when you able to make your own medical decisions you should do so even if they are different from what you document in this directive.

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

1. 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, a close friend, or a competent adult 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.

Note: The only changes you can make to this document, once it is complete, relate to changes in contact information. Designating a new or different healthcare agent necessitates the creation of a new document.

Designating a health care agent is highly recommended. 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 1, cross out that section and go on to section 2.

2. THE AUTHORITY I GIVE MY AGENT

This section identifies the authorities you give to your Health Care Agent. If there is a particular authority you do not wish your Health Care Agent to assume, cross it out and initial the change.

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.

3. WHY I AM MAKING THIS DOCUMENT

This section is especially important when no health care agent is named in section 1. 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. It allows you to attach an additional statement that describes and reinforces values expressed in your document. However, no additional statement to section 3 is necessary or required. You may want to write in more specific terms about 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 a certain family member will not honor your wishes or might 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, non-terminally-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.

4. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

Qualities of life I consider worse than death. Initialed items indicate you would not want anything done to prolong your life including life-sustaining treatment if such a life-threatening event should occur.

(a) Unconsciousness or coma resulting in the permanent inability to think and communicate:

Another doctor must agree with your attending physician's opinion that the condition is probably permanent. 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.

(b) Irreversible dementia:

Dementia is irreversible when caused by a degenerative disease or trauma. It might be reversible in some cases when caused by drugs, alcohol, hormone or vitamin imbalances, or depression. If my dementia is deemed irreversible by a qualified physician with the concurrence of another physician, I want to forego life-sustaining treatment.

(c) Total dependence on others for my care because of physical deterioration, which is probably permanent:

If I am no longer able to turn in bed, take care of personal minimal hygiene (bathing, grooming) or toileting needs, and/or feed myself, I want to forego life-sustaining treatment.

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

If I experience unrelenting, intolerable pain which cannot be alleviated to my satisfaction by pain medication, I want to forego life-sustaining treatment.

(e) 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 4(a) through 4(e) 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 a terminal diagnosis or 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.

5. WHEN I MAY WANT TEMPORARY LIFE-SUSTAINING TREATMENT

Sometimes it is hard for physicians to know if using life-sustaining treatment for a short period of times 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. If you want to temporarily receive life-sustaining treatment you should indicate a time limit for receiving that treatment in the first option, or choose the second option if you want your Health Care Agent - in consultation with the doctor – to determine the length of treatment if it is not producing the hoped-for improvement.

6. 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 otherwise. This section identifies life-sustaining procedures you would not want started or continued. It also applies to the conditions you have initialed and documented in Section 4. 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.

7. 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 nor legal concern. Developing a tolerance to pain medication is not addiction. Do not leave this section blank; initial yes or no.

8. 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.

9. MY WISHES CONCERNING OTHER MATTERS

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 9.

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. Note: the donation of your organs or tissue may not always be possible.
- c. I consent to an autopsy.
After death, physicians sometimes want to do autopsies to obtain information about an injury or disease process that could help them treat other patients. Your refusal of an autopsy may not be honored.
- 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). Note: your body donation may not be accepted; so be sure to make alternate plans.
- 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. If you do not use this section, cross it out. 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, People's Memorial Association, or another organization that assumes responsibility for your body after death, there is no need to complete this part. If you do not use this section, cross it out.

10. 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.

11. 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 of the entire document.

The Advance Directive with the latest date will always take precedence over one with an older date.

12. 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.

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

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.
- Your home care provider or a care provider at an adult family home or long-term care facility where you live.

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 notarize an advance directive and make an appointment. Ask if they can provide witnesses or bring your own witnesses with you). End of Life Washington provides complimentary notarization of advance directives in our Seattle-area 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, 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. 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 when they travel.
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 (see Item 5 below).
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, check the Document Library at www.endoflifewa.org or 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), check the Document Library at www.endoflifewa.org or 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. Remember, the Advance Directive with the most recent date is the one that will be followed.

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. The advance directive with the latest date takes precedence over previous advancedirectives.
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.



**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 make my own health care decisions. I understand that such inability may only be temporary. 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.

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 9.

1. MY HEALTH CARE AGENT

I appoint as my primary agent:

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

My alternate agent {optional}:

If my primary agent is unable or unwilling to serve, or is unavailable 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 primary agent is unavailable, I intend that the alternate agent act only until my primary agent is available.

2. 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) employing and dismissing health care providers; (d) changing my health care insurers; (e) signing a Physician Orders for Life-Sustaining Treatment (POLST) form; (f) transferring me to another facility, private home, or other place; and (g) accessing my medical records and information. This authority applies to information governed by the Health Insurance Portability and Accounting Act (HIPAA) of 1996 and any further changes to HIPAA.

3. WHY I AM MAKING THIS DOCUMENT/ 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. 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. 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.

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

4. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

I value life very much, but I believe that to be kept alive in certain circumstances is worse than death. If I initial an item in this section it means that if such an initialed life-threatening event should occur, I would not want to receive life-sustaining treatment. I want my care-givers to focus on comfort care and pain management, and I should be allowed to die as peacefully as possible: {initial all that apply}

_____ a. Unconsciousness or coma that probably will prevent me from communicating, permanently.

_____ b. Irreversible dementia such as Alzheimer's Disease.

_____ c. Total dependence on others for my care because of physical deterioration, which is probably permanent.

_____ d. Pain which probably cannot be eliminated, or can be eliminated only by sedating me so heavily that I cannot converse.

_____ e. Below are other circumstances in which I would not want life-sustaining treatment:
{Optional}

5. WHEN I MAY WANT TEMPORARY USE OF LIFE-SUSTAINING TREATMENT

I understand that I could become unconscious or unable to communicate, *temporarily*. If I were to become unconscious or unable to communicate temporarily, then (initial only *ONE* line):

_____ I would want to receive life-sustaining treatment, for up to _____ weeks (please specify)

_____ I would want to receive life-sustaining treatment for a period of time determined by my health care agent, based on the judgement of my doctor(s).

_____ I still would want no life-sustaining treatment.

6. LIFE-SUSTAINING TREATMENTS I DO NOT WANT

If I experience a condition in which I would not want life-sustaining treatment (as documented in Section 4), or if I experience a quality of life my agent believes I would consider unacceptable, I do not want the following life-sustaining treatments started. If already started, I want them stopped.

{Initial all that you **do not** want.}

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

_____ Artificial ventilation when I can no longer breathe on my own.

_____ Heart-regulating drugs, if my heartbeat becomes irregular.

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

_____ Surgeries for the purpose of prolonging my life rather than for providing comfort.

_____ Dialysis if my kidneys do not work normally.

_____ Medications, treatments or procedures, when their primary purpose is to prolong life rather than control pain.

_____ Anything else intended to prolong my life.

7. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION

If I am experiencing symptoms such as pain, breathlessness, or visible discomfort, I want treatment to relieve my pain and symptoms and make me

Yes

No

comfortable, even if medical providers believe this might unintentionally hasten my death, cause drug dependency, or make me unconscious.

8. IF A HEALTH CARE PROVIDER REFUSES TO HONOR MY DECISIONS OR DECISIONS OF MY HEALTH CARE AGENT

(Cross out this section, if you do not agree.)

If I am ever in a health care facility that refuses to honor my decisions expressed in this document or decisions made for me by my health care agent, I want my agent to take whatever actions he or she decides are appropriate to secure those decisions, including but not limited to changing my physician(s) or moving me out of the facility.

9. 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 agent(s) for funeral arrangements: | | |

My agent for funeral arrangements:

Name

Address

Telephone
(day)

(evening)

(mobile)

My alternate agent for funeral arrangements (if my primary agent is unable or unwilling to serve, or if my agent is a spouse or partner from whom I am separated or divorced when decisions need to be made for me):
{optional}

Name

Address

Telephone
(day)

(evening)

(mobile)

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

10. 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.

11. 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. Note: The signed and witnessed Advance Directive with the latest date will take precedence over older Advance Directives.

12. 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.}

13. STATEMENT OF WITNESSES

{Print the legal name of the person making this document on this line.}

is personally known to me, and I believe this person to be of sound mind and to have completed this document voluntarily. I affirm I am at least 18 years old, not related to the signer of this document by blood, marriage, or adoption, and am not their health care agent named in this document. As far as I know I am not a beneficiary of the signer's will or any codicil, and I have no claim against their estate. I am not directly involved in their health care, and I am not an employee of their physician or a health care facility where the person making this document may reside. I am not a home care provider for this person, nor am I a care provider at an adult family home or long-term care facility in which this person resides.

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 their 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 _____