WASHINGTON

HEALTH CARE DIRECTIVE

DIRECTIVE made this ____ day of _____, 20___.

I, **JOHN SAMPLE**, of 123 Main Street, Seattle, Washington 98104, 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 here by 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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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.

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otherwise to receive part of the declarant's estate. I am not the declarant's attending physician or an employee of that physician or of a health facility in which the declarant is a patient.

_____ _____

[signature – please print name under this line] [street address]

_____

[city, state]

_____ _____

[signature – please print name under this line] [street address]

_____

[city, state]