Living Will with Health Care Power of Attorney
(Revised Code of Washington 70.122.030)

1. If I am unable to give directions about the use of life-sustaining treatment, I want my family and any physician to honor this directive as the final assertion of my legal right to refuse medical treatment.

2. I direct any physician to withhold or withdraw life-sustaining treatment and to let me die if at any time I should either

A. have, in the written opinion of my attending physician, an incurable injury, disease, or illness, causing an irreversible terminal condition that will cause death within a reasonable period of time, and if the use of life-sustaining treatment would serve only to artificially prolong the process of dying, or

B. be diagnosed in writing by two physicians, one of whom is my attending physician and both of whom have personally examined me, to be in a permanent unconscious condition.

3. I do not want either cardiopulmonary resuscitation (manual or mechanical efforts to restore heartbeat or breathing after they have stopped) or assisted ventilation (use of a respirator to help keep a person breathing) under the circumstances described in 2(A) or (B) above.

4. **I do / I do not** [circle one and cross out the other] want tube feeding (use of a tube through the nose or abdomen for feeding a person who can't take food by mouth) under the circumstances described in 2(A) or (B) above.

5. **I do / I do not** [circle one and cross out the other] want artificial hydration (giving liquids by tube or intravenously to a person who can't drink) under the circumstances described in 2(A) or (B) above unless it is necessary for my comfort.

Health Care Power of Attorney

6. I give a durable power of attorney to _____ to make decisions for me, consistent with my living will, about medical treatment, including the withholding or withdrawal of medical treatment, in the event that my treating physician determines I have lost the mental capacity to make such decisions for myself.

Date: _____

_____
Signature

Printed name:_____

Address:_____
street address city state

Statement of Witnesses

The maker of this living will (the "declarer") signed it in my presence. He or she has been personally known to me and I believe him or her to be capable of making health care decisions, to understand this living will, and to have signed it voluntarily. I am not related by blood or marriage to the declarer, and I am not now entitled to receive any portion of the declarer's estate, either by

will or by operation of law, or as a result of any claim against the declarer. I am not the declarer's attending physician or an employee of that physician or of a health facility in which the declarer is a patient.

Date: _____

Witness: _____
Signature / Address

Witness: _____
Signature / Address