ADVANCE DIRECTIVE: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This advance directive, a durable power of attorney for health care, allows you to name your health care agent. This form meets the requirements of Washington state law.

My Information:

FULL NAME: PRONOUNS (optional):
(i.e., he/she/they)

DATE OF BIRTH: / /
(mm/dd/yyyy)

NAMING A HEALTH CARE AGENT

The person I designate as my health care agent is:

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

The people I designate as my alternate agents are:

If the person listed above is unable or unwilling to make my health care decisions, then I designate the people listed below as my first and second alternate health care agents.

First Alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

Second Alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

Initial below if this situation applies to you. You may draw a line through statement if it does not apply to you. For more information: see the ACP Overview.

____ If I name my spouse or registered domestic partner as my health care agent and we later file for a dissolution, annulment, or legal separation; I want them to continue as my health care agent.

Guidance for my healthcare agent

Write information you want your health care agent to know about your health care wishes.

AUTHORIZING A HEALTH CARE AGENT

Statement of General Authority and Powers of My Health Care Agent: I authorize my health care agent to give consent for medical treatments when I cannot make my own decisions. I authorize my health care agent to carry out my wishes regarding life-support treatments such as a CPR, breathing machines, feeding tubes, blood transfusions, and kidney dialysis. This includes consent to start, continue, or stop medical treatment.

I attest to the following: I understand the importance and meaning of this durable power of attorney for health care (DPOA-HC). This form reflects my health care agent choices. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can revoke and replace this form at any time. I revoke any prior durable power of attorney for health care. I want this DPOA-HC to become effective if a physician or licensed psychologist determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

MY SIGNATURE: DATE:

ADDRESS, CITY, STATE, ZIP:

Witnesses or Notary Requirement

You must have your signature either witnessed by two people or acknowledged by a notary public.

OPTION 1 – TWO WITNESSES

Witness Attestation: I declare I meet the rules for being a witness.

WITNESS #1 SIGNATURE: DATE:

NAME PRINTED:

WITNESS #2 SIGNATURE: DATE:

NAME PRINTED:

Rules for Witnesses:

- Must be at least 18 years of age and competent.
- Cannot be related to you or your health care agent by blood, marriage, or state registered domestic partnership.
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Cannot be your designated health care agent.

OPTION 2 – NOTARY

STATE OF WASHINGTON)
)
COUNTY OF)

This record was acknowledged before me on this day of ,

by (name of individual):

Signature: Title: Exp:

NAME:

DATE OF BIRTH: / /
(mm/dd/yyyy)