DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I,_____(name), living in the city of_____,

in the county of_____, in the state of Washington,

designate_____(name) as my attorney in fact, to act for me in making health care decisions if I become incapacitated. I hereby revoke any and all health care powers of attorney previously granted by me.

1. **Alternate Attorney in Fact.** If for any reason_____(name) fails to act, or is not able to act, I designate_____(name) then_____(name) as alternate attorneys in fact, to serve in the order named. An attorney in fact my resign be delivering written notice to that effect, in recordable form, to an alternate, successor, or co-attorney in fact. In this Durable Power of Attorney for Heath Care, the "attorney in fact" means the then acting attorney in fact.
2. **Power to Make Health Care Decisions.** My attorney in fact shall have the right to make decisions, and to give informed consent on my behalf, as to my health care, to the extent permitted by law. This authority shall include, but not be limited to, the right to consent to the withholding or withdrawal of life-sustaining treatment which would only prolong artificially the moment of my death and prevent me from dying naturally, in those circumstances in which a physician(s) has/have determined (a) that I am in a permanent unconscious condition, meaning, 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, or (b) that I have a terminal condition, meaning 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. I also authorize my attorney in fact to make decisions regarding the artificial administration of food and fluids, consistent with any Health Care Directive (living will) I have executed.
3. **Effectiveness.** This Durable Power of Attorney for Health Care shall become effective upon my incapacity. Incapacity shall include the inability to make health care decisions effectively for reasons such as mental illness, mental deficiency, incompetency, physical illness or disability, advanced age, chronic use of drugs or chronic intoxication. Incapacity may be determined by (a) a court order or (b) a written qualified attending physician.
4. **Duration.** This Durable Power of Attorney for Health Care becomes effective as provided in Section 3 above and shall remain in effect to the fullest extent permitted by Chapter 11.94 of the Revised Code of Washington, or until revoked to terminated as provided in Section 5 or 6 below.
5. **Revocation.** This Durable Power of Attorney for Health Care may be revoked, suspended, or Terminated by written notice from me to the designated attorney in fact and, if this power has been recorded, by recording this notice in the office where deeds as recorded for real estate located in _____County, Washington.
6. **Termination.** If appointed, my guardian may, with court approval, revoke, suspend, or terminate this Durable Power of Attorney for Health Care.
7. **Reliance.** Any person dealing with the assigned attorney in fact shall be entitled to rely upon this Durable Power of Attorney for Health Care to carry out my wishes for health care. No one shall deal with this attorney in fact if they know or have written notice of any cancellation, revocation, suspension or termination of this Durable Power of Attorney for Health Care. Any action so taken, unless otherwise invalid or unenforceable, shall be binding on my relatives or inheritors of my estate.

8. **Indemnity.** My estate shall hold harmless and indemnify the attorney in fact from all liability for acts or omissions done in good faith.
9. **Applicable.** The laws of the State of Washington shall govern this Durable Power of Attorney for Health Care.
10. **Execution.** This Durable Power of Attorney for Health Care is signed on the_____day of _____, 20_____, to be effective as provided in Section 3 above.

Signature of Declarer_____

NOTE: Washington State requires this directive to be notarized or witnessed by two different witnesses.

Witness _____ Witness _____

WITNESS REQUIREMENTS: The witnesses to this document must be competent and must NOT be:

- Home care providers for the individual completing this document;
- Care providers at an adult family home or long-term care facility if you live there; or
- Related to you or the designated Health Care Agent by blood, marriage, or state registered domestic partnership.

Notarization:

STATE OF WASHINGTON

COUNT OF_____

I certify that I know or have satisfactory evidence that the GRANTOR,
Signed this instrument and acknowledged it to be his/her free voluntary act for the uses and purposes mentioned in the instrument.

Dated this_____day of_____, 20_____.

_____
NOTARY PUBLIC in and for the State of Washington

Residing at_____

My commission expires_____