HEALTH CARE DIRECTIVE

Directive made this_____day of_____, _____
(Year)

I,_____being of sound mind, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

A. If at any time I should have an incurable and irreversible condition certified to be a terminal condition by my attending physician, 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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.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 "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.

B. If I should be in an irreversible coma or persistent vegetative state, or other permanent unconscious condition as certified by two physicians, and from which those physicians believe that I have no reasonable probability of recovery, I direct that life-sustaining treatment be withheld or withdrawn.

C. If I am diagnosed to be in a terminal or permanent unconscious condition, *[Choose one]*
I want ○ do not want ○
artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me to honor this directive.

D. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

E. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

F. I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this directive at any time.

(Continued on page two)

PLACE PATIENT LABEL HERE

G. I make the following additional directions regarding my care:

Signed: _____

FORM CONTINUES ON NEXT PAGE

NOTARIZATION

State of Washington County of _____

I certify that I know or have satisfactory evidence that the Grantor, _____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on _____

SIGNATURE OF NOTARY _____

PRINT NAME OF NOTARY _____

NOTARY PUBLIC for the State of Washington

My commission expires: _____

WITNESSES

In lieu of notarization, this document may be witnessed by two competent persons who are NOT:

- Entitled to any portion of the declarer's estate by will or codicil;
- Attending physician, an employee of the physician or health facility in which declarer is a patient;
- Any person who has a claim against any portion of the declarer's estate; or
- Related to the declarant by blood, marriage, or state registered domestic partnership.

Witness Name _____ Signature_____

Witness Name _____ Signature_____

FAX completed form to UW Medicine HIM for scanning into the Medical Record: 206-520-3251