DURABLE POWER OF ATTORNEY FOR HEALTH CARE – Page 1 of 2

I understand that my wishes as expressed in my living will may not cover all possible aspects of my care. If I become incapacitated or unable to speak for myself, there may be a need for someone to accept or refuse medical intervention on my behalf, in consultation with my physician.

Therefore, as a resident of Washington state,

I, (please print full name)_____, as principal, designate and appoint the person(s) listed below as my attorney-in-fact for health care decisions.

First Choice:

Name:_____

Address:_____

City/State/Zip Code:_____

Home phone number:_____

Alternate phone number:_____

If the above person is unable, unavailable, or unwilling to serve, I designate:

Second Choice:

Name:_____

Address:_____

City/State/Zip Code:_____

Home phone number:_____

Alternate phone number:_____

1. This Power of Attorney shall take effect upon my inability to make my own health care decisions, as determined by my treating physician and one other physician, and shall continue as long as the incapacity lasts or until I revoke it, whichever happens first.

2. The powers of my attorney-in-fact under this Power of Attorney are limited to making decisions about my health care on my behalf. These powers shall include the power to order the withholding or withdrawal of life-sustaining treatment if my attorney-in-fact believes, in his or her own judgment, that is what I would want if I could make the decision myself. The existence of this Durable Power of Attorney for Health Care shall have no effect upon the validity of any other Power of Attorney for other purposes that I have executed or may execute in the future.

3. In the event that a proceeding is initiated to appoint a guardian of my person under RCW 11.88, I nominate the person designated as my first choice to serve as my guardian. My second choice will serve as my guardian if the first person is unable or unwilling.

4. I make the following additional instructions regarding my care:

By signing this document, I indicate that I understand the purpose and effect of this Durable Power of Attorney for Health Care.

Dated this _____ day of _____, 20_____
(date) (month) (year)

Signed:_____

Printed name:_____

The person named as principal in this document is personally known to me. I believe that he/she is of sound mind, and that he/she signed this document freely and voluntarily.

Witness:_____

Witness:_____