

LIVING WILL / DIRECTIVE TO PHYSICIANS – Page 1 of 2

This Directive was made _____, I, _____,
(month / day / year) (printed full name)

having the capacity to make health care decisions, 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:

1. I understand by using this form that:
 - **“a 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, and where the application of life-sustaining treatment would serve only to prolong the process of dying.
 - **“a permanent unconscious condition”** means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgement as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.
2. If at any time I should be diagnosed in writing
 - to be in a terminal condition by the attending physician, or
 - in a permanent unconscious condition by two physicians,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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn and I be permitted to die naturally.
3. In the absence of my ability to give directions regarding the use of life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences of such refusal.
If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that person be guided by this directive and any other clear expressions of my desires.
4. If I have been diagnosed as pregnant and that diagnosis is known to my physician(s), this directive shall have no force or effect during the course of my pregnancy.
5. I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.
6. I understand that before I sign this directive I can add to or delete from, or otherwise change the wording of this directive, and that any changes shall be consistent with Washington State or federal constitutional law to be legally valid.
7. It is my wish that every part of this directive be fully implemented. If, for any reason, any part is held invalid it is my wish that the remainder of my directive be implemented.

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8. I make the following additional (optional) instructions regarding my care:

If I am diagnosed to be in a terminal condition or a permanent unconscious condition (check one):

- I DO want to have artificially provided nutrition and hydration.
- I DO NOT want to have artificially provided nutrition and hydration.

Other additional (optional) instructions regarding my care:

ORGAN DONATION (OPTIONAL):

1. Under Washington law, an anatomical gift made by a donor and not revoked by them before death is irrevocable and does not require consent or concurrence of any person after the donor's death. The law also authorizes any reasonable examination necessary to assure the medical acceptability of the anatomical gift.
2. An individual may amend or revoke an anatomical gift at any time by:
a signed statement, an oral statement made in the presence of two individuals, any form of communication during a terminal illness or injury, or the delivery of a signed statement to a specified donee to whom a document of gift had been delivered.
3. An individual may refuse to make an anatomical gift by:
a signed statement, a statement attached to or imprinted on a donor's driver's license, another writing used to identify the individual as refusing to make an anatomical gift, or an oral statement other form of communication during a terminal illness or injury.

 I DO NOT want to make an organ or tissue donation and I do not want my agent or family to do so
 I have already signed a written agreement or donor card regarding organ/tissue donation

Signed: _____

Printed name: _____

City, County, State of residence: _____

The declarer in this document is personally known to me. I believe him/her capable of making health care decisions and signed this document freely and voluntarily.

Witness: _____
Signature printed named/city of residence

Witness: _____
Signature printed named/city of residence