



# Powers of Attorney and Health Care Directives

---

You may have thought about which friend or relative you would choose to make decisions for you if you become injured or sick. You may have even thought about what kinds of medical treatment you will want if you are terminally ill or in a coma. But have you written it down? A **power of attorney** document allows you to choose a trusted friend or relative to help you with your health care and/or finances. A **health care directive** tells your friends, family and medical providers what kinds of treatment you want if you cannot speak for yourself.

## What is a Power of Attorney for Finances?

In a power of attorney for finances document, you choose someone you trust with your money (your “agent”) to act on your behalf and help you with your money, property and belongings. You can give your agent the power to do things like pay your bills, take money out of your bank account, or buy and sell your property. If you make your power of attorney “durable”, your agent can keep helping you even if you become sick or injured and cannot make decisions for yourself. You can still make your own decisions about your finances. You can change or cancel your power of attorney at any time.

## What is a Power of Attorney for Health Care?

In a power of attorney for health care document, you choose someone you trust with your health care (your “agent”) to act on your behalf and help you with health care decisions. You can give your agent the power to do things like access your medical records and approve medical treatment. If you make your power of attorney “durable”, your agent can keep helping you even if you become sick or injured and cannot make decisions for yourself. You can still make your own decisions about your health care. You can change or cancel your power of attorney at any time.

## What is a Health Care Directive?

In a health care directive (also called a “living will”), you choose the end-of-life medical procedures you do not wish to have if you become terminally ill or permanently unconscious. The types of treatment you can reject include feeding tubes, ventilators, IV hydration, and CPR. You can also express your general values regarding your health care in this document. You can still make your own decisions as long as you are able and you can change or cancel the health care directive at any time.

## Power of Attorney FAQs

What powers can I give my agent?	You can give your agent virtually all the powers you currently have to transact business and make medical decisions, including the power to buy and sell your things, withdraw money from your bank account, view your medical records, approve your medical treatment, etc.
Do I have to list every power separately?	<b>No.</b> But, there are a few special powers you have to specifically mention if you want your agent to have them, including the power to refuse an inheritance, change the beneficiary of your life insurance policy, give gifts of your property or money, and transfer property into a trust.
Can I limit my agent's powers?	<b>Yes.</b> You get to decide what powers you want to give your agent.
What does "durable" mean?	"Durable" means that your agent can still use the power of attorney document to help you even if you become sick or injured and cannot make decision for yourself.
When does my durable power of attorney document start working?	You can decide whether you want your durable power of attorney document to start immediately or only when you cannot make decisions for yourself.
How long does my durable power of attorney document last?	Your durable power of attorney document ends when you die. You can write in an earlier end date or event if you choose.
Do I lose the power to make decisions when I sign a durable power of attorney document?	<b>No.</b> A durable power of attorney document does not cancel your power to take actions or make decisions for yourself. It just duplicates the powers you have in a second person so that he/she can act for you if you need that assistance.
What if my agent starts doing things I don't like?	You can cancel ("revoke") your durable power of attorney document. You should destroy the document and any copies and give a written notice of revocation to the agent. You can also give written notice of revocation to your medical providers, anyone that holds your property (e.g. Department of Licensing for car title) and banks where you have accounts.

What if I want someone else to be my agent?	You can cancel (“revoke”) your durable power of attorney document and make a new one. You should destroy the old document and any copies and give a written notice to the old agent and new agent.
Does my durable power of attorney document have to be notarized?	The law does not require notarization. But, it’s a good idea to have your durable power of attorney for <u>finances</u> notarized because some banks and government agencies require it.
Do I also need to get a legal guardian?	<b>No.</b> A legal guardian is selected by a judge during a court case after the judge determines that a person is mentally unable to make decisions for him/herself.
Can my agent admit me to inpatient mental health treatment or authorize shock therapy?	<b>No.</b> Generally, your agent would need a court order for these acts. However, if you have a mental health disability, you can prepare a Mental Health Advance Directive that authorizes voluntary inpatient treatment and special procedures.
What should I do with my durable power of attorney after I sign it?	You should make copies. Give the original to your agent, a copy to your alternate agent, and keep a copy for yourself.

## Health Care Directive FAQs

Is a “living will” different from a health care directive?	<b>No.</b> A health care directive lets you choose medical procedures that you do <u>not</u> wish to have if you become terminally ill or <u>permanently</u> unconscious. Some people call this document a “living will”.
Is a POLST form different from a health care directive?	<b>Yes.</b> A Physician Orders for Life-Sustaining Treatment (POLST) form is a set of medical orders that follow your preferences for end-of-life treatment in your home if you have a terminal or serious illness. POLST forms are bright green. They must be signed by an authorized medical provider.
Do medical providers have to honor my health care directive?	<b>No.</b> Providers may refuse to follow your health care directive due to personal or religious beliefs or hospital policy. Your agent should find providers and hospitals that will follow your health care directive.

What medical procedures can I say I do <u>not</u> want if I'm terminally ill or in a permanent coma?	The next few boxes briefly describe common end-of-life medical procedures you may not want if you are terminally ill or in a permanent coma. However, you should talk to your medical provider about these procedures and other procedures or medications.
What is a feed tube or IV hydration?	A medical procedure where you are given nutrients and fluids through a tube placed directly into your stomach, upper intestine, or vein to supplement or replace ordinary eating and drinking.
What is ventilation?	A medical procedure where a machine called a respirator or ventilator forces air into your lungs to support or replace the function of the lungs. The ventilator is attached to a tube inserted in your nose or mouth and down into your windpipe.
What is cardiopulmonary resuscitation (CPR)?	A medical procedure where someone else makes your heart and lungs work by compressing your chest and forcing air into your lungs when your heart and/or breathing stops. Electric shock and drugs may also be used to stimulate your heart
What is blood dialysis?	A medical procedure where a machine filters harmful wastes, salt and excess fluid from your blood when your kidneys stop working.
What is a blood transfusion?	A medical procedure where donated blood is given to you through an intravenous line to replace lost or contaminated blood.
What if I want to change my health care directive?	You can cancel your health care directive and make a new one. You should destroy any old health care directives.
Does my health care directive have to be notarized?	<b>No.</b>
Does my health care directive have to be witnessed?	<b>Yes.</b> You must sign your health care directive in front of two witnesses. The witnesses can't be (a) related to you by blood or marriage, (b) entitled to receive any portion of your estate, or (c) your attending physician or an employee of your health care facility.
What should I do with my health care directive after I sign it?	You should show your health care directive to your medical provider, trusted friends and/or relatives and talk with them about your end-of-life wishes. You should store the original in a safe place.

## What is a Mental Health Directive?

A mental health directive allows you to make decisions in advance about your mental health treatment and values, including preferred medications, who are your trusted health care providers, advance consent to short-term admission to inpatient treatment, and what treatments and care help you most to improve your mental health and avoid hospitalization. A Mental Health Directive is especially important during times when you cannot make decisions for yourself due to your mental illness. You can find a Mental Health Directive on the Washington Law Help website: [www.washingtonlawhelp.org](http://www.washingtonlawhelp.org).

## What is an Alzheimer's Disease/Dementia Mental Health Advance Directive?

An Alzheimer's Disease/Dementia Mental Health Advance Directive is a mental health directive for people who have been diagnosed with Alzheimer's disease and/or dementia, who have a family history of Alzheimer's disease, or who simply want to plan for this possibility. The directive allows you to document your wishes related to where to live, how to finance your care, your driving preferences, your sexual relationships, and many other issues while you have the capacity to do so. The directive can be

a helpful tool for talking with your friends and family about your wishes for the future. You can find an Alzheimer's Disease/Dementia Mental Health Advance Directive published by Compassion & Choices of Washington on the Washington Law Help website: [www.washingtonlawhelp.org](http://www.washingtonlawhelp.org).

## What if I need legal help?

If you live outside King County, call the CLEAR hotline Monday-Friday from 9:15 am to 12:15 pm, at 1-888-201-1014. Individuals aged 60 or over may call CLEAR\*Sr during the same time frame at 1-888-387-7111, regardless of income. You can also apply online at <http://nwjustice.org/get-legal-help>.

If you live in King County, call 211 for information and referral to an appropriate legal services provider Monday through Friday from 8:00 am – 6:00 pm. You may also call (206) 461-3200, or the toll-free number, 1-877-211-WASH (9274). [www.resourcehouse.com/win211/](http://www.resourcehouse.com/win211/).

Callers who are deaf and hard of hearing can call 1-800-833-6384 or 711 to get a free relay operator. They will then connect you with 211 or CLEAR.

---

This publication provides general information concerning your rights and responsibilities. It is not intended as a substitute for specific legal advice.

This information is current as of August 2015.

© 2015 Seattle University School of Law Clinical Program & Northwest Justice Project

(Permission for copying and distribution granted to the Alliance for Equal Justice and to individuals for non-commercial purposes only.)

This page is intentionally left blank.

# Durable Power of Attorney for Finances for

\_\_\_\_\_  
[My Name]

1. **My Agent.** I, \_\_\_\_\_, a resident of the State of Washington, appoint \_\_\_\_\_, as my Agent with full authority to manage my finances. I revoke any Power of Attorney for Finances I may have given in the past. See Exhibit A for my Agent's contact information.
2. **Alternate.** If for any reason my Agent becomes unable or unwilling to act, I appoint \_\_\_\_\_, as my Agent with full authority to manage my finances. See Exhibit A for my Alternate Agent's contact information
3. **Durable Power of Attorney.** This Power of Attorney shall not be affected by my disability and will remain in effect to the extent permitted by RCW 11.94 or until revoked.
4. **Effective Date.** This Power of Attorney shall become effective: *(initial the choice that applies)*  
\_\_\_\_\_ Immediately.  
  
\_\_\_\_\_ Upon my written notice or written notice by my physician stating that I lack the mental capacity to make important decisions independently. See Exhibit B for Certificate of Physician.
5. **Revoking My Power of Attorney.** I may revoke this Power of Attorney by a written notice mailed or delivered to my Agent. See Exhibit C for Revocation Notice.
6. **General Powers of My Agent.** My Agent shall have full power and authority to do anything as fully and effectively as I could do personally if I were alive and competent. This power shall include, but not be limited to: the power to make deposits to, and payments from, any account in my name in any financial institution; the power to open and remove items from any safe deposit box in my name; the power to sell, exchange or transfer title to stocks, bonds or other securities; the power to sell, convey or encumber any real or personal property.
7. **Special Powers of My Agent.** My Agent shall have the following special powers:  
*(initial all choices that apply; cross out choices that do not apply)*  
  
\_\_\_\_\_ Disclaimer: My Agent shall have the authority to disclaim any interest in any property which I would otherwise inherit, as provided in RCW 11.86.

\_\_\_\_\_ Beneficiaries: My Agent shall have the power to make, amend, alter, or revoke any of my life insurance, annuity, or similar contract beneficiary designations, employee benefit plan beneficiary designations, trust agreements, registration of my securities in beneficiary form, payable on death or transfer on death beneficiary designations, transfer on death deeds, designation of persons as joint tenants with right of survivorship with me with respect to any of my property, community property agreements, or any other provisions for nonprobate transfer at death contained in nontestamentary instruments described in RCW 11.02.091.

\_\_\_\_\_ Trusts: My Agent shall have the authority to exercise my rights to distribute property in trust or cause a trustee to distribute property in trust to the extent consistent with the terms of the trust agreement, and to make transfers of property to any trust (whether or not created by the principal) unless the trust benefits the principal alone and does not have dispositive provisions which are different from those which would have governed the property had it not been transferred into the trust.

8. **Gifts.** My Agent shall have the authority to make gifts for the purpose of qualifying for public benefits or avoiding liens against my property.
9. **Reimbursement of Costs.** My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this document.
10. **Nomination of Guardian.** I nominate my Agent as the guardian of my person or estate for consideration by the court if protective proceedings for my person or estate are hereafter commenced.
11. **Accounting.** My Agent shall keep accurate records of my financial affairs, including documentation of all transactions in which my Agent is involved. Upon request, my Agent shall present such records to me, a successor Agent, a guardian of my estate or person, or to the acting personal representative or executor named in my Will.
12. **Ratification and Indemnity.** I hereby ratify all that my Agent shall lawfully do or cause to be done by virtue of this document. I shall hold harmless and indemnify my Agent from all liability for acts done in good faith.

13. **HIPAA Release.** I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to My Agent, including, but not limited to, my medical billing statements.

\_\_\_\_\_  
My Signature

\_\_\_\_\_  
Date

**Notarization**

State of Washington

County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that \_\_\_\_\_, 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 \_\_\_\_\_.

This page is intentionally left blank.

EXHIBIT A

Contact Information for Agent and Alternates as of the Date of Signing

My Agent's Name			
Address			
Phone		Email	

My Agent's Name			
Address			
Phone		Email	



My Alternate Agent's Name			
Address			
Phone		Email	

My Alternate Agent's Name			
Address			
Phone		Email	

This page is intentionally left blank.

EXHIBIT B

Certificate of Physician

The undersigned certifies:

- (1) I am a physician licensed to practice medicine in the State of \_\_\_\_\_.
- (2) I have examined \_\_\_\_\_. I find that he or she is physically and/or mentally disabled or incapacitated and is incapable of:
  - (a) making health care decisions, or
  - (b) managing his or her property, or
  - (c) conducting his or her affairs.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Address & Phone:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This page is intentionally left blank.

EXHIBIT C

**Revocation of Power of Attorney**

I, \_\_\_\_\_, hereby revoke the Durable Power of Attorney I gave to  
\_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Notarization** (optional)

State of Washington

County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that \_\_\_\_\_, 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 \_\_\_\_\_.

This page is intentionally left blank.

# Durable Power of Attorney for Health Care for

\_\_\_\_\_  
[My Name]

1. **My Agent.** I, \_\_\_\_\_, a resident of the State of Washington, appoint \_\_\_\_\_, as my Agent with full authority to make health care decisions on my behalf. See Exhibit A for my Agent's contact information.
2. **Alternate.** If for any reason my Agent becomes unable or unwilling to act, I appoint \_\_\_\_\_, as my Agent with full authority to make health care decisions on my behalf. See Exhibit A for my Alternate Agent's contact information.
3. **Durable Power of Attorney.** This Power of Attorney shall not be affected by my disability and will remain in effect to the extent permitted by RCW 11.94 or until revoked.
4. **Effective Date.** This Power of Attorney shall become effective: (*initial the choice that applies*)  
\_\_\_\_\_ Immediately.  
  
\_\_\_\_\_ Upon my written notice or written notice by my physician stating that I lack the mental capacity to make important decisions independently. See Exhibit B for Certificate of Physician.
5. **Revoking My Power of Attorney.** I may revoke this Power of Attorney by a written notice mailed or delivered to my Agent. See Exhibit C for Revocation Notice.
6. **Powers of Agent.** I hereby grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my Agent shall make health care decisions consistent with my desires as stated in this document or otherwise made known to my Agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life sustaining care, treatment, services and procedures. The power and authority to make health care decisions shall include, but not be limited to, the following:
  - 6.1 **Access to Medical Records.** I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information in my medical records which my Agent may request. With respect to my Agent only, I hereby waive all privileges attached to the physician patient relationship and to any communication, verbal or written, arising out of such a relationship. My Agent is authorized to request, receive and

review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations and health care providers as my Agent may designate.

- 6.2 HIPAA Release.** In addition to the other powers granted by this document, I grant to my Agent the power and authority to serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended from time to time, and its regulations. My Agent will serve as my “HIPAA personal representative” and will exercise this authority at any time that my Agent is exercising authority under this document.
- 6.3 Health Care Providers.** My Agent is authorized to employ and discharge health care providers, including physicians, psychiatrists, dentists, nurses and therapists, as my Agent shall deem appropriate for my physical, mental and emotional well-being.
- 6.4 Admission to Facilities.** My Agent is authorized to apply for my admission to a medical, nursing, residential or other similar facility, execute any consent or admission forms required by such facility and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Agent may designate. My Agent is not authorized to arrange for my commitment to or placement in a mental health treatment facility, except pursuant to RCW 71.05.
- 6.5 Consent to Procedures.** My Agent is authorized to arrange for and consent to medical, therapeutic and surgical procedures for me, including the administration of drugs. My Agent is not authorized to arrange for or consent to electroconvulsive therapy. The power to make health care decisions for me shall include the power to give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.
- 6.6 Visitation.** My Agent shall have the unfettered right to visit me at any hospital or other medical facility where I reside or receive treatment.
- 6.7 Reserved Rights.** Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself so long as I am able to give informed consent with respect to a particular decision.

**6.8 Withdrawal of Life-Sustaining Procedures.** *(initial the choice that applies)*

\_\_\_\_\_ I have executed a Health Care Directive expressing my intentions with respect to the use, continuation, or withdrawal of life sustaining procedures; thus, I direct my Agent to take all appropriate steps to implement my directions.

\_\_\_\_\_ I have not executed a Health Care Directive at this time.

- 7. **Reimbursement of Costs.** My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this document.
- 8. **Nomination of Guardian.** I nominate my Agent as the guardian of my person or estate for consideration by the court if protective proceedings for my person or estate are hereafter commenced.
- 9. **Accounting.** My Agent shall keep accurate records of my financial affairs, including documentation of all transactions in which my Agent is involved. Upon request, my Agent shall be required to present such records to me, a successor Agent, a guardian of my estate or person, or to the acting personal representative or executor named in my Will.
- 10. **Ratification and Indemnity.** I hereby ratify all that my Agent shall lawfully do or cause to be done by virtue of this document, and I shall hold harmless and indemnify my Agent from all liability for acts done in good faith.

\_\_\_\_\_  
My Signature

\_\_\_\_\_  
Date

**Notarization** (optional)

State of Washington  
County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that \_\_\_\_\_, 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 \_\_\_\_\_.

EXHIBIT A

Contact Information for Agent and Alternates as of the Date of Signing

My Agent's Name			
Address			
Phone		Email	

My Agent's Name			
Address			
Phone		Email	



My Alternate Agent's Name			
Address			
Phone		Email	

My Alternate Agent's Name			
Address			
Phone		Email	

This page is intentionally left blank.

EXHIBIT B

Certificate of Physician

The undersigned certifies:

(3) I am a physician licensed to practice medicine in the State of \_\_\_\_\_.

(4) I have examined\_\_\_\_\_. I find that he or she is physically and/or mentally disabled or incapacitated and is incapable of:

(d) making health care decisions, or

(e) managing his or her property, or

(f) conducting his or her affairs.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Address & Phone:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This page is intentionally left blank.

EXHIBIT C

**Revocation of Power of Attorney**

I, \_\_\_\_\_, hereby revoke the Durable Power of Attorney I gave to  
\_\_\_\_\_.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Notarization** (optional)

State of Washington

County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that \_\_\_\_\_, 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 \_\_\_\_\_.

This page is intentionally left blank.

# Health Care Directive of

---

[My Name]

As a person with capacity, I willfully and voluntarily execute this Health Care Directive. 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 all medical providers as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences of such refusal. If I have appointed another person to make health care decisions for me, whether through a durable power of attorney or otherwise, then I request that my agent be guided by my desires as expressed in this directive or as otherwise communicated to my agent. 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.

- 1. Withhold and Withdraw Treatment.** If at any time I should be diagnosed in writing to be in a terminal condition by my physician, or in a permanent unconscious condition by two physicians, and where the application of life sustaining treatment would serve only artificially to prolong the process of my dying, I direct that the following treatment be withheld or withdrawn: *(initial the choices that apply)*

\_\_\_\_ Artificial nutrition.

\_\_\_\_ Artificial hydration.

\_\_\_\_ Artificial respiration.

\_\_\_\_ Cardiopulmonary Resuscitation (CPR) , including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure.

\_\_\_\_ Surgery to prolong my life or keep me alive.

\_\_\_\_ Blood dialysis or filtration for lost kidney function.

\_\_\_\_ Blood transfusion to replace lost or contaminated blood.

\_\_\_\_ Medication used to prolong life, not for controlling pain.

\_\_\_\_ Any other medical treatment used to prolong my life or keep me alive.

2. **Comfort Care and Pain Medication.** If at any time I should be diagnosed in writing to be in a terminal condition by my physician, or in a permanent unconscious condition by two physicians, I want treatment to relieve my pain and symptoms and make me comfortable if I appear to be in pain or experiencing other signs of discomfort, even if my physicians or other medical providers believe this might unintentionally hasten my death.
  
3. **Health Care Institutions – Refusal to Honor My Advance Directive.** If I am a patient at a health care institution whose policy is to decline to follow advance directives that conflict with certain religious or other beliefs when this document comes into effect, I direct that my consent to admission shall not constitute implied consent to procedures or courses of treatment that conflict with this advance directive. Moreover, if a health care institution declines to follow my wishes set out in the advance directive when this document comes into effect, I direct that I be transferred as soon as possible to a hospital, nursing home, or other institution that will honor the instructions provided in this document.
  
4. **Changes and Revocation.** I understand that, before I sign this directive, I can add to or delete from or otherwise change the wording of this directive. I further understand that at any time I may revoke this directive entirely or execute a new directive with different provisions. Any changes must be consistent with Washington State law or federal constitutional law to be legally valid.
  
5. **Pregnancy.** If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive: *(initial the choice that applies)*  

\_\_\_\_\_ shall still have full force and effect during the course of my pregnancy.

\_\_\_\_\_ shall have no force or effect during the course of my pregnancy.
  
6. **Additional Directions:** I make the following additional directions regarding my care:

I have signed this document in the presence of two witnesses.

\_\_\_\_\_

My Signature

\_\_\_\_\_

Date

**Statement of Witnesses**

On \_\_\_\_\_, the maker of this document signed it in my presence. He or she is personally known to me and I believe him or her to be capable of making health care decisions, to understand this document, and to have signed it voluntarily.

- I am not related by blood or marriage to him or her.
- I am not now entitled to receive any portion of his or her estate, either by will or by operation of law, or as a result of any claim against him or her.
- I am not his or her attending physician or an employee of that physician or of a health facility in which he or she is a patient.

**Witness 1**

**Witness 2**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_

\_\_\_\_\_