Durable Power of Attorney for Health Care

I, _____, domiciled in the State of Washington, designate _____ as my attorney in fact, to act for me in making health care decisions if I become incapacitated. I hereby revoke all health care powers of attorney previously granted by me.

1. Alternate Attorney in Fact. If for any reason _____ fails or ceases to act, I designate _____, then _____ as alternate attorneys in fact, to serve in the order named. An attorney in fact may resign by delivering written notice to that effect, in recordable form, to an alternate, successor, or co-attorney in fact. In this Power of Attorney, 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. This authority shall include, but not be limited to, consent to the withholding or withdrawal of life-sustaining treatment, including*/but not including* artificially provided nutrition and hydration, if at any time (1) I should be diagnosed in writing by my attending physician to be in a terminal condition (an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable amount of time in accordance with accepted medical standards) or (2) in a permanent unconscious condition (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 persistent vegetative state) by two physicians; and where the application of life-sustaining treatment would serve only to artificially prolong the process of dying. I give this authority with the intent that it be honored by my attorney-in-fact to permit me to die naturally.

* (cross out one)

3. Effectiveness. This Power of Attorney 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, chronic use of drugs or chronic intoxication. Incapacity may be determined (i) by court order or (ii) by a qualified regularly attending physician, whose affidavit in recordable form to that effect shall be conclusive of incapacity. An affidavit executed as described herein may be relied upon without inquiry by any person dealing with the attorney in fact.

4. Duration. This Power of Attorney becomes effective as provided in Section 3 and shall remain in effect to the fullest extent permitted by Chapter 11.94 of the Revised Code of Washington, or until revoked or terminated as provided in Section 5 or 6.

5. Revocation. This Power of Attorney 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 the notice in

the office where deeds are recorded for real estate located in _____ County, Washington.

6. Termination. If appointed a guardian of my person may, with court approval, revoke, suspend, or terminate this Power of Attorney.

7. Reliance. Any person dealing with the attorney in fact shall be entitled to rely upon this Power of Attorney so long as the person with whom the attorney in fact was dealing, at the time of any act taken pursuant to this Power of Attorney, had neither actual knowledge nor written notice of any revocation, suspension, or termination of this Power of Attorney. Any action so taken, unless otherwise invalid or unenforceable, shall be binding on my heirs, devisees, legatees, or personal representatives.

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 Law. The internal law of the State of Washington shall govern this Power of Attorney.

10. Execution. This Power of Attorney is signed in duplicate on the _____ day of _____, to be effective as provided in Section 3.

_____ Signed _____ Witness
_____ Witness

Notarization, If Needed:

STATE OF WASHINGTON)) ss. COUNTY OF _____)

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

Dated: _____.

(Seal or stamp) _____ Notary Public in and for the State of Washington, residing at _____ My appointment expires _____

(A power of attorney must be signed and dated by the principal, and the signature must be either (1) acknowledged before a notary public or other individual authorized by law to take acknowledgments; or (2) attested by two or more witnesses. A witness must not be a home care

provider for the principal nor care providers at an adult family home or long-term care facility in which the principal resides; or related to the principal or agent by blood, marriage, or state registered domestic partnership. Exceptions are provided under RCW 11.125.050 in the case the principal is physically unable to sign his or her name.)