(iii) Initial the one statement that reflects your desires. You should cross out the statement you **do not** agree with.

_____ If I am diagnosed to be in a terminal condition or permanent unconscious condition, I ***do*** want to have artificially provided nutrition and hydration.

— OR —

_____ If I am diagnosed to be in a terminal condition or permanent unconscious condition, I ***do not*** want to have artificially provided nutrition and hydration.

(iv) Additionally, I give these instructions about my care:

_____
_____
_____
_____
_____
_____
_____

b. To consent to donate any needed organs, tissue or parts of my body as indicated by my initials. You should cross out the statements you ***do not*** agree with.

_____ To benefit others for the purpose of transplantation only.

_____ To benefit others for the purposes of transplantation and/or anatomical study or research.

— OR —

_____ I ***do not*** wish to donate my organs, tissue or parts of my body for any purpose.

3. Effectiveness.
This Power of Attorney shall become effective upon my disability, incapacity or incompetence. My disability, incapacity or incompetence shall be determined by a physician who is familiar with my medical condition or by a court of competent jurisdiction. If determined by a physician, this Power of Attorney shall become effective when the physician has provided to my Agent a written statement that I am either disabled, incapacitated or incompetent.

4. Reliance.
All persons dealing with my Agent shall be entitled to rely on this Power of Attorney so long as they have no actual knowledge that it has been terminated.

5. Termination.
This Power of Attorney shall remain in effect until revoked or terminated by me, a court appointed guardian or a court order.

6. Law.
The laws of the State of Washington shall govern this Power of Attorney.

Dated this_____day of_____, in the year_____.

Signed_____

STATE OF WASHINGTON
COUNTY OF_____

On this day personally appeared before me, _____, to me known to be the individual described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her free and voluntary act and deed for the uses and purposes therein mentioned.

Given under my hand and official seal this_____day of_____in the year_____.

_____
Notary Public in and for the State
of Washington, residing in_____.
My appointment expires_____.

#ZO4445 Rev. 2/04
Administration/Ethics/Power of Attorney.pmd

A GUIDE TO CREATING **A DURABLE POWER OF ATTORNEY** FOR HEALTH CARE

Cover photo: Kib and Pat Servine, Thomas Jones, M.D.

INSTRUCTIONS FOR COMPLETING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Choosing Your Agent

This is a legal document. It allows you to pick the person who will make decisions about your medical care if you become incapable of doing so.

You may choose anyone you like to make these decisions for you. Married people usually select their spouses. You may not select your doctor, any of your doctor's employees, or an employee of a hospital or nursing home where you might be a patient. However, you may choose a person who is so employed if that person is related to you by blood, marriage or adoption.

This document will refer to that person as your "Agent." It will also allow you to pick alternates in case the first person you pick is later unwilling or unable to make these decisions. Of course, you should ask the person in advance whether he or she is willing to serve as your Agent.

You may revoke your Agent's authority at any time by simply telling or writing your doctor or hospital. Remember, too, that your Agent will make choices for you ***only if*** you become unable to do so.

Choosing Medical Care

After choosing your Agent, you can also use this document to indicate the kinds of medical care you wish to receive and the kinds you don't. You should talk over your preferences with your Agent and your doctor because they will cooperate to reach decisions in keeping with your preferences and medical condition.

Completing This Document

You can fill out this document without going to an attorney. However, if you have any questions about this document, you should consult with an attorney or your doctor. It is recommended that you sign this document in the presence of a notary public, although it is not legally required that you do so. (Your bank probably has a notary public who can notarize this for you.)

Keep this document with your other important papers, where it is accessible to your Agent. You should give a copy of this document to your Agent and your doctor.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. Designation of Agent for Healthcare Decisions.

I, _____, as principal, designate and appoint the following persons in the order listed below as my attorneys-in-fact for health care decisions (hereafter, Agent). If the first person listed is unable to serve, I then appoint the second person.

First Designee: Name _____
Address _____
City/State/Zip _____
Telephone _____

Second Designee: Name _____
Address _____
City/State/Zip_____
Telephone _____

2. Powers Related to Health care Decisions.

My Agent for health care decisions shall have the following powers:

a. To make health care decisions on my behalf, including giving informed consent to healthcare providers. Included in this power is the authority to make decisions about life-prolonging medical procedures, such as (but not limited to) placement of tubes to provide nutrition or hydration, antibiotics and cardiopulmonary resuscitation. Also, my Agent may specifically request and concur with the writing of a "no-code" (Do Not Resuscitate) order by my attending physician. All of this is to be in keeping with my directives as indicated by my initials next to the following paragraph(s).

(i) [Initial the one statement that reflects your desires. You may select only one. You should cross out the statement you ***do not*** agree with.]

_____ I want my life to be prolonged and I want life-prolonging treatment to be provided if, in my Agent's judgment, the probable benefit of treatment outweighs its anticipated pain, discomfort, or other burden. I want my Agent to consider the relief of suffering/pain and the quality, as well as length of the possible extension of my life, in making decisions about life-prolonging medical procedures.

— OR —

_____ I want my life to be prolonged to the greatest extent possible, without regard to the pain, discomfort and other anticipated burdens that would be incurred, so long as there is a chance for survival.

(ii) [Initial either one of the following statements or both that reflect your desires. You should cross out statements you ***do not*** agree with.]

_____ **TERMINAL CONDITION**
If I should be in an incurable or irreversible physical condition with no expectation of recovery, I do not want any treatment that will merely prolong my dying. Thus, I want my treatment limited to medical and nursing measures that are intended to keep me comfortable, to relieve pain and to maintain my dignity.

_____ **PERMANENT UNCONSCIOUS CONDITION**
If I am in a coma or a vegetative state which my doctors reasonably believe to be permanent, I do not want any life-prolonging treatment to be provided or continued.