~ Washington ~

Durable Power of Attorney For Health Care Christian Version

NOTICE TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document you should know these facts:

• This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you and is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.

• You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you if you choose.

• Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

• When exercising his or her authority to make health care decisions for you when deciding on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by attaching them to this document or by making them known in another manner.

• When acting under this document the Health Care Agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care agent, close family, or friends, if needed.

STATE OF WASHINGTON DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Written in accordance with Washington RCW 11.125

Document made this _____ day of _____, _____.
Month Year

CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____ (hereinafter referred to as "Principal"),
Print full legal name

_____, _____/_____/_____
Address Date of birth

intend to create a Health Care Agent by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so. This designation becomes effective when I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions.

DESIGNATION OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT(S)

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I designate and appoint:

_____ (hereinafter referred to as "health care agent"),
Health care agent

_____, _____,
Address City, State, Zip

(_____) _____
Phone number

as my health care agent by granting him or her the Durable Power of Attorney for Health Care and authorize her or him to consult with my physicians about the possibility of regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.to be my health care agent.

In the event that the person listed above is unable or unwilling to serve, then I grant these powers to the people listed below as my first and second alternate choices.

1st Alternate Name

Print name: _____ Phone: (_____) _____

Address: _____

City, State, Zip: _____

2nd Alternate Name

Print name: _____ Phone: (_____) _____

Address: _____

City, State, Zip: _____

EFFECTIVE DATE

This power of attorney shall become effective upon the disability of the principal.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES

My health care agent may admit me to a nursing home for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

A nursing home **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 9-13)

If I have not checked either "Yes" or "No" immediately above, my health care agent may only admit me for short- term stays for recuperative care or respite care.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 9-13)

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withheld or withdrawn from me.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my health care agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my he or she knows I am pregnant.

Health care decisions if I am pregnant **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 9-13)

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my health care agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that the attached Addendum (pages 9-13) be included as a valid part of this Durable Power of Attorney for Health Care document.

2. I request, but not as a requirement, that my health care agent consult my clergy regarding health care decisions.

3. _____

_____

_____

_____

_____

[Attach additional pages, if needed.]

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

1. Request, review and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my health care agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The principal's signature must be witnessed at the same time by two witnesses or a notary public.

SIGNATURE OF PRINCIPAL

(Person creating the Durable Power of Attorney for Health Care)

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

Dated this _____ day of _____, _____.
Month Year

Signature: _____

(The signing of this document by the principal revokes all previous durable power of attorney for health care documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this Durable Power of Attorney for Health Care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee of an inpatient health care facility in which the declarant is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

---------- ***OR*** ----------

STATE OF WASHINGTON

(COUNTY OF _____)

I certify that I know or have satisfactory evidence that the GRANTOR, _____,

signed this document and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instruction.

DATED this _____ day of _____, _____
Month Year

_____

NOTARY PUBLIC in and for the State of Washington

Residing at _____

Printed name _____

My Commission Expires _____

STATEMENT OF HEALTH CARE AGENT

I understand that _____ has designated me to be his or her health care agent
Name of principal
if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Signature of health care agent: _____

Address: _____

STATEMENT OF FIRST ALTERNATE HEALTH CARE AGENT

I understand that _____ has designated me to be his or her first
Name of principal
alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Signature of first alternate health care agent: _____

Address: _____

STATEMENT OF SECOND ALTERNATE HEALTH CARE AGENT

I understand that _____ has designated me to be his or her second
Name of principal
alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent or first alternate health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Signature of second alternate health care agent: _____

Address: _____

ANATOMICAL GIFTS

Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

ADDENDUM TO THE STATE OF WASHINGTON DURABLE POWER OF ATTORNEY FOR HEALTH CARE

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief that life is a gift from God and in the inherent value of human life. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

(I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.)

HEALTH CARE DIRECTIVES

1. I direct my health care agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death with occur within hours or a few days, my health care agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care agent may consent to the withholding or withdrawal of life-sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care agent may consent to the withholding or withdrawal of life-sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Durable Power of Attorney for Health Care document, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

The principal's signature must be witnessed at the same time by two witnesses or a notary public.

SIGNATURE OF PRINCIPAL

(Person creating the Durable Power of Attorney for Health Care)

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

Dated this _____ day of _____, _____.
Month Year

Signature: _____

(The signing of this document by the principal revokes all previous durable power of attorney for health care documents.)

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this Durable Power of Attorney for Health Care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, or an employee of an inpatient health care facility in which the principal is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

---------- ***OR*** ----------

STATE OF WASHINGTON

(COUNTY OF _____)

I certify that I know or have satisfactory evidence that the GRANTOR, _____,

signed this document and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instruction.

DATED this _____ day of _____, _____
Month Year

_____

NOTARY PUBLIC in and for the State of Washington

Residing at _____

Printed name _____

My Commission Expires _____

STATEMENT OF HEALTH CARE AGENT

I understand that _____ has designated me to be his or her health care agent
Name of principal
if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Signature of health care agent: _____

Address: _____

STATEMENT OF FIRST ALTERNATE HEALTH CARE AGENT

I understand that _____ has designated me to be his or her first
Name of principal
alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Signature of first alternate health care agent: _____

Address: _____

STATEMENT OF SECOND ALTERNATE HEALTH CARE AGENT

I understand that _____ has designated me to be his or her second
Name of principal
alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent or first alternate health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Signature of second alternate health care agent: _____

Address: _____

CLERGY
Optional

The principal has requested that the health care agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the health care agent to help meet the directives as described in this Durable Power of Attorney for Health Care document and attached Addendum.

Signature of Clergy: _____ Phone: (_____) _____

Church address: _____

I have given copies of this Durable Power of Attorney for Health Care – Christian Version to:

_____

_____

_____

_____

_____

_____