

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Durable Power of Attorney for Health Care of _____

1. Designation of Health Care Agent. I, _____, hereby appoint _____ as my Health Care Attorney in Fact, (herein referred to as "Agent"), to make health and personal care decisions for me as authorized in this document. If _____ dies, becomes legally disabled, resigns, refuses to act or is unavailable, or if I revoke that person's authority to act as my Agent, I then designate and appoint _____ as the successor to my Agent.

2. Effective Date and Durability. By signing this document I intend to create a durable power of attorney for health care under RCW Chapter 11.94. This durable power of attorney for health care shall not become effective until written evidence of incompetence or of the determination of disability is made by two of my attending physicians. It shall survive such incompetence or disability and shall continue during that incapacity to the extent permitted by law or until I revoke it. The authority to receive medical information shall take effect immediately upon execution.

3. Purpose. I am signing this document in recognition of my fundamental right to control the decisions relating to my medical care; in recognition of my rights to make such decisions subject only to countervailing, compelling state interests; in recognition that those rights belong equally to the competent as well as the incompetent; in recognition that modern medical technology has made possible the prolonging of life and/or postponement of death; and in recognition that such prolonging of life and/or postponement of death may cause loss of dignity and unnecessary pain and suffering while providing nothing medically necessary or beneficial.

4. Powers Regarding Health Care Decisions and Over the Person of the Principal. I grant to my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or otherwise known to my Agent. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If I am unconscious, comatose, senile, or otherwise unreachable by such communication, my Agent should make the decision guided primarily by my preferences as expressed in this document, any preferences which I may have previously expressed and as expressed in any Health Care Directive, Directive to Physicians, or "Living Will" that I have executed.

Accordingly, unless specifically limited below, my Agent shall have the authority to make all the health care decisions to the same extent I could make for myself if I had the capacity to do so, including, without limitation, the following:

4.1 Health Care Decisions; Consent. Consent to giving, withholding or stopping any treatment, service, or procedure to diagnose, maintain, or treat my physical or mental condition; consent to my medical and surgical care and non-treatment, including experimental form of treatment or procedures; consent to the withholding or withdrawal of life-sustaining treatment; and to make

any and all health care decisions on my behalf and to sign forms necessary to carry out health care decisions.

4.2 Employ and Discharge Others. To employ and discharge physicians, psychiatrists, dentists, nurses, therapists, and other professionals as my Agent may deem necessary for my physical, mental and emotional well-being or to advise or assist my Agent in the performance of the duties of the Agent.

4.3 Fees and Costs. To pay reasonable and necessary fees and costs incurred in carrying out the powers and duties under this document, including reasonable reimbursement for the costs advanced by the Agent, from my assets.

4.4 Agreement Regarding My Care. To enter into any agreement for my care.

4.5 Arrange for My Care. Arrange for my hospitalization, convalescent care, or home care. I ask my Agent to be guided in making such decisions by what I have told my Agent about my personal preferences regarding such care, and by any Health Care Directive that I have executed.

4.6 Right to Refuse Treatment. Summon paramedics or other emergency medical personnel and seek emergency treatment for me, or choose not to do so, as my Agent deems appropriate given my wishes, any Health Care Directive that I may have executed and my medical status at the time of the decision; to sign documents titled or purported to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice," as well as any necessary waivers of or releases from liability required by the hospitals or physicians to implement my wishes regarding medical treatment or non-treatment; request and concur with the writing of a "no-code" (DO NOT RESUSCITATE) order by the attending or treating physician.

4.7 Consent or Refuse Consent to My Psychiatric Care. Upon the execution of a certificate by two (2) independent psychiatrists who have examined me, who are licensed to practice in the state of my residence and in whose opinions I am in immediate need of hospitalization because of mental disorders, alcoholism, or drug abuse, to arrange for my voluntary admission to an appropriate hospital or institution for treatment of the diagnosed problem or disorder; to arrange for private psychiatric and psychological treatment for me; to refuse consent for any such hospitalization, institutionalization and private psychiatric and psychological care; and to revoke, modify, withdraw or change consent to such hospitalization, institutionalization and private treatment which my Agent or I may have given at an earlier time.

4.8 Health Care Records; Medical Information. To have access to all my medical and health records, and to consent to the disclosure of such records pursuant to the Uniform Health Care Information Act with the same power and authority that I would have to authorize such disclosure; to obtain any information whatsoever regarding my personal affairs or physical or mental health from any person, including any physician, hospital, nurse, medical attendant, technician or health care or nursing facility or personnel, and I waive any privilege to such information in favor of my Agent.

4.9 Withdrawal of Consent to Treatment. To revoke or change any consent previously given or implied by law to any medical care or treatment.

4.10 Execute Documents. To sign, execute, deliver and acknowledge such documents in writing of whatever kind and nature as may be necessary or proper in accordance with the powers granted herein, including (but not limited to) granting any waiver or release liability required by any hospital, physician, or other health care provider.

4.11 Legal Action. To pursue any legal action in my name, and at the expense of my estate for force compliance with my wishes as determined by my Agent or to seek damages for the failure to comply.

4.12 Provide Me Relief From Pain. To consent to and arrange for the administration of painrelieving drugs of any type or other surgical or medical procedures calculated to relieve my pain, even though their use might lead to permanent physical damage, addiction, or even hasten the moment of my death. To consent to and arrange for unconventional pain relief therapies such as biofeedback, guided imagery, relaxation therapy, acupuncture or cutaneous stimulation and other therapies which my Agent or I believe may be helpful to me.

[OPTION-ANATOMICAL GIFTS]

4.13 Anatomical Gifts. To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law.

[OPTION-DOMESTIC PARTNER]

4.14 Visitation. I authorize and direct any physician, surgeon, nurse, hospital or other medical personnel or care facility to give _____ first priority in visitation should I be unable to express a preference because of my illness or disability and be a patient in any hospital, health care facility, hospice or other institution; and give her all personal property that may be recovered from or about my person at the time of my illness, disability or death. In addition to my Agent and domestic partner, visitation shall also be given to my following close friends:

Such contact from my domestic partner and my friends is necessary for my well being. My family may not totally approve of my lifestyle, and it is my specific direction that my wishes regarding my partner and my friends and my absolute right of free association be honored, whether or not I am able to express my opinion due to any disability.

[OPTION-CONSULT WITH PARENTS]

4.15 It is my direction that my Agent consult with my parents regarding decisions made over my person or regarding medical treatment or the withholding or withdrawal of medical treatment, but that she be given full power to exercise independent judgment in this regard. It is merely my wish that she discuss and consult in good faith with my parents prior to making her independent

decision, provided time permits. No physician or health care provider shall require proof of such consultation, and such person(s) shall be entitled to rely solely upon my Agent.

4.16 Remain in Home. Authorize my Agent to express, on my behalf, my desire to reside in my home whenever possible and if I should be placed in a nursing home, desire and intent to return to my home from such nursing home, if possible.

5. Constitutional Rights. I intend that the decisions of any health care agent that I have duly appointed be constitutionally protected as if I had made such decision(s) while competent, and hereby grant such powers and constitutionally or otherwise protected rights as I would have if competent.

6. Health Care Directive. The Agent shall take into account and honor the wishes of the Principal as reflected in any Health Care Directive, Directive to Physicians, or similar "Living Will" executed by the Principal, and shall have the power to interpret my intent as to the meaning of said Directive or "Living Will."

7. Substituted Judgment/Best Interest. In exercising the powers granted in this document, the Agent shall make a substituted judgment lot the Principal to do what the Principal would do (if the Principal were competent to make a decision and understood all the circumstances, including the Principal's present and future competency) regarding any matter relating to the rendering of medical, health and/or nursing care to the Principal. But if the Agent is unable to make such a substituted judgment for the Principal on those matters, the Agent shall act according to a good faith determination by the Agent as to the best interests of the Principal regarding any such matter relating to the rendering of medical, health and/or nursing care to the Principal.

8. Restriction on Consent. Life sustaining treatment may not be withdrawn or withheld from the Principal if the Principal objects thereto, notwithstanding any provision to the contrary contained in this document.

9. Reliance; Protection of Third Parties Relying on My Agent. No person who relies in good faith upon any representations by my Agent or any successor Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority. All persons dealing with the Principal's acting Agent hereunder shall rely on the apparent authority of the Agent, unless they have actual knowledge of the invalidity in the execution or revocation of this document.

10. Nomination of Guardian. It is my intent to avoid the necessity of Guardianship proceedings and the power given to my Agent herein should be broadly construed to accomplish such purpose. If the appointment of a Guardian or Limited Guardian of my person is sought, I nominate my Agent (or her successor) named above to serve as Guardian or Limited Guardian of my person. If the designation of Guardian hereunder shall conflict with the designation of Guardian under any other Power of Attorney executed by me, then the Guardian under this Power of Attorney for Health Care shall control as the Guardian of my person.

[OPTION-DOMESTIC PARTNER VISITATION]

11. Domestic Partner Visitation. If for any reason a person other than my Agent (or her successor) is appointed as Guardian or Limited Guardian of my person, or is exercising power under this Power of Attorney, said person shall not deny visitation to _____ or my other close friends and shall give her/them first priority in visitation. Such contact from supportive, loving, and caring friends is necessary to my well being. In order to clarify, my family may not totally approve of my lifestyle, but it is my specific direction that my wishes regarding my friends, my partner, and my absolute right of free association regardless of whether I am disabled or able to make or communicate that decision for myself be honored. This clause may be specifically enforced by any person or class of persons identified in this paragraph, or by such person's guardian or limited guardian.

[OPTION-PERSONS WHO MAY NOT MAKE DECISIONS]

12. I specifically hereby make known my desire, my instruction, and my directive that the following family members not be authorized to make any decisions regarding my person, my medical or other care, or my instructions in my Health Care Directive, and that they not be appointed at any time to act as guardian in any capacity on my behalf:

[OPTION GUARDIAN FOR FUTURE CHILDREN]

13 Nomination of Guardian for Minor Children. Should it become necessary to appoint a guardian for my minor child(ren) hereafter born or adopted by me, due to my disability or incapacity, it is my direction and I hereby nominate and appoint _____ to serve as guardian of the person, property and estate of any of my minor children. I specifically hereby make known my desire and my instruction, and my directive that the following family members not be authorized to make any decisions regarding the person, estate, medical or other care of my minor child(ren), and that they not be appointed at any time to act as guardian or limited guardian of my minor child(ren) in any capacity:

14. Addition to Medical Record. This document shall be made a part of the permanent medical record of the Principal upon the Principal's admission to a health care facility.

15. Definitions.

(a). Unless some other meaning and intent is apparent from the context, the plural shall include the singular and vice versa, and masculine, feminine and neuter words shall be used interchangeably.

(b) All references to children shall include born and unborn issue and adopted persons.

(c) All references to descendants shall include adopted persons.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Durable Power of Attorney for Health Care on this _____ day of _____, 2001.

PRINCIPAL

Residing at:

WITNESS STATEMENT

I declare that the person who signed or acknowledged this document is personally known to me, that she signed or acknowledged this Durable Power of Attorney for Health Care in my presence, and that she appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as Agent by this document, nor am I the principal's health care provider or an employee of the principal's health care provider. I further declare that I am not related to the Principal by blood, marriage or adoption, and to the best of my knowledge, I am neither a creditor of the Principal's nor entitled to any part of her estate under a will now existing or by operation of law.

WITNESS (signature)

Print name

Address

City, State, Zip Code

WITNESS (signature)

Print name

Address

City, State, Zip Code

SUBSCRIBED AND SWORN TO before me this _____ day of _____ 2001.

Notary (signature)

Print name

NOTARY PUBLIC in and for the State of Washington,
residing at _____

My commission expires _____