

Durable Power of Attorney for Health Care

I, _____, domiciled in the State of Washington, designate _____ as my attorney in fact, to act for me 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. To the extent permitted by law, this shall include, but not be limited to, the right to consent to the withholding or withdrawal of life-sustaining procedures which would only prolong artificially the moment of my death and prevent me from dying naturally, in those circumstances where my physicians have determined (a) that I am in a comatose or persistent vegetative state from which there is no reasonable probability of my recovery, or (b) that I have a terminal condition and my death is imminent unless, or even if, such life-sustaining procedures are utilized. I include in these life-sustaining procedures the artificial administration of food and fluids.

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, advanced age, 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 on the _____ day of _____, to be effective as provided in Section 3.

Signed _____

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

Dated: _____

Notary Public in and for the State of Washington

(Seal or Stamp)

residing at _____

My appointment expires _____