Durable Power of Attorney for Health Care

(Washington Revised Code §§ 11.94.010 to 11.94.900)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care agent in case of my incapacity.

2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.

3. **Regarding end-of-life matters:** [initial one of the two choices]

   (a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.

   (b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.

4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

5. I give no one (including my agent) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.

6. Apart from the matters covered above, I appoint the person named herein as my agent to make health-care decisions for me. I give my agent full power and authority to consent to or to refuse treatment (including artificial nutrition and hydration) on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed agent is unavailable, unable, or unwilling to serve, I appoint an

alternate agent herein to serve with the same power and authority. This Durable Power of Attorney for Health Care shall become effective upon my disability.

(Signature*) (Date)

(Address)

STATEMENT OF WITNESSES: The principal (the person who signed above) signed this document in my presence and is personally known to me. He or she appears to be of sound mind and free from duress, fraud, or undue influence. I am 18 years of age or older. **I am not (1) the health-care agent or alternate agent appointed in this document,** (2) related to the principal by blood or marriage, (3) entitled to any portion of the principal's estate upon the principal's death under any will or codicil existing at the time of the execution of this document or by operation of law, (4) the principal's attending physician, (5) an employee of the principal's attending physician or of a health facility in which the principal is a patient, or (6) a person who has a claim against any portion of the principal's estate upon the principal's death at the time of the execution of this document.

(Signature of witness) (Signature of witness)

(Address) (Address)

HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

ALTERNATE HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

* **Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your health-care agents). You should sign this document in the presence of two witnesses. You may appoint any adult to be your agent except (1) your nonrelative physician, (2) a nonrelative employee of your physician, or (3) the nonrelative owner, administrator, or employee of the health-care facility or long-term care facility where you reside or receive care. A "nonrelative" is a person who is not your spouse, adult child, or brother or sister.

Durable Power of Attorney for Health Care
(signed document inside)

NO BLOOD