WASHINGTON
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

I understand that my wishes as expressed in my living will may not cover all possible aspects of my care if I become incapacitated. Consequently, there may be a need for someone to accept or refuse medical intervention on my behalf, in consultation with my physician.
Therefore,

I, **JOHN SAMPLE**, of 123 Main Street, Seattle, Washington, as principal, designate and appoint my wife JANE SAMPLE, of the same address, as my attorney-in-fact for health care decisions to the same extent that I could make such decisions for myself if I were capable of doing so, as recognized by RCW 11.94.010.

If my wife is unable, unwilling or unavailable to act, or if I revoke her appointment or authority to act, then I designate the following persons to serve as my attorney-in-fact for health care decisions as authorized in this document, such persons to serve in the order listed below:

First Alternate Attorney-in-Fact: My brother JOSEPH DOE

Second Alternate Attorney-in-Fact: My sister SUSAN DOE

1. This Power of Attorney shall take effect upon my incapacity to make my own health care decisions, as determined by my treating physician and one other physician, and shall continue as long as the incapacity lasts or until I revoke it, whichever happens first.

2. The powers of my attorney-in-fact under this Power of Attorney are limited to making decisions about my health care on my behalf. These powers shall include the power to order the withholding or withdrawal of life-sustaining treatment if my attorney-in-fact believes, in his or her own judgment, that is what I would want if I could make the decision myself. The existence of this Durable Power of Attorney for Health Care shall have no effect upon the validity of any other Power of Attorney for other purposes that I have executed or may execute in the future.

3. In the event that a proceeding is initiated to appoint a guardian of my person under RCW 11.88, I nominate the person designated as my first choice (on page 1) to serve as my guardian. My second choice (on page 1) will serve as my guardian if the first person is unable or unwilling.

SAMPLE

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5. I make the following additional instructions regarding my care:

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(Add additional sheets if necessary.)

6. I revoke any prior Advance Health Care Directive and any prior Durable Power of Attorney for Health Care. The existence of this Durable Power of Attorney for Health Care shall have no effect upon the validity of any other Power of Attorney for other purposes that I have executed or may execute in the future.

7. Persons dealing with my attorney-in-fact may rely fully on a photocopy of this document as though the photocopy was an original.

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

Dated this _____ day of ____________, 20___.

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JOHN SAMPLE

STATE OF WASHINGTON)
) ss.
COUNTY OF KING)

I certify that I know or have satisfactory evidence that JOHN SAMPLE is the individual who appeared before me, and said person acknowledged that he signed this instrument and acknowledged it to be his free and voluntary act for the uses and purposes mentioned in this instrument.

Dated: ________________________, 20___

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Notary name printed or typed: ____________________

Residing at: ______________________________

My appointment expires: ________________

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