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How to Complete Your Washington Health Care Directive

Health Care Directive (Washington Natural Death Act, RCW 70.122.030)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This is Washington's statutory health care directive (living will), current through the 2025 amendments. It tells your doctors to withhold or withdraw life-sustaining treatment if you are in a terminal or permanent unconscious condition.

1. **Fill in and choose (Page 1)**
   Enter the date and your name, and check one choice about artificially provided nutrition and hydration.
2. **Sign one of two ways (Pages 2–3)**
   Washington allows **two qualified witnesses** (Page 2) **or** a **notary** (Page 3). Witnesses must meet strict rules, so many people choose the notary. We can provide witnesses for an additional fee.

After It's Signed

- Give a copy to your doctor so it becomes part of your medical records, and to your hospital, agent, and family.
- Pair it with a Washington Durable Power of Attorney for Health Care. We have a free form.

Need a Notary and Witnesses? We Come to You.

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Qualified witnesses available for an additional fee.

Washington-Commissioned Notaries

SCAN TO BOOK

Questions about this document? Talk to an attorney. Gavrilov & Brooks Law Firm has attorneys licensed in multiple states. Phone and video consultations are available, wherever you are. **(916) 504-0529** · **www.gavrilovlaw.com**

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YOUR FORM BEGINS ON THE NEXT PAGE

HEALTH CARE DIRECTIVE

(Washington Natural Death Act, RCW 70.122.030)

Directive made this

day | of (month, year)

I

Full name of declarer

having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

☐ I DO want to have artificially provided nutrition and hydration.

☐ I DO NOT want to have artificially provided nutrition and hydration.

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(d) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(e) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(f) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

Other directions (optional):

X

Signed

Printed name

City, County, and State of Residence

Sign in ONE of two ways: before a **notary** (recommended) **or** before **two qualified witnesses**.

OPTION 1: WITNESSES. The declarer has been personally known to me or has provided proof of identity and I believe him or her to be capable of making health care decisions. Neither of us is related to the declarer by blood or marriage, entitled to any part of the declarer's estate, the attending physician or an employee of the physician or of a health facility where the declarer is a patient, or a person with a claim against the declarer's estate.

X

Witness

Printed name

X

Witness

Printed name

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OPTION 2: NOTARY ACKNOWLEDGMENT

STATE OF WASHINGTON)
COUNTY OF) **ss.**
)

This record was acknowledged before me on

(date) by (name of declarer)

X
Notary Public

(Notary seal)

Notary's printed name

Title (Notary Public, State of Washington) My commission expires

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