INSTRUCTIONS FOR COMPLETING THE POWER OF ATTORNEY FOR HEALTH CARE FORM

IMPORTANT:

1. Before filling out this form, **READ THE WARNINGS THAT ACCOMPANY THIS FORM.**

2. On lines 1-4 of the form, provide the name, address and phone number of the person who will be your attorney-in-fact for health care decisions. The attorney-in-fact must be a competent adult 18 years of age or older at the time of appointment.

   YOU MAY NOT NAME THE FOLLOWING AS YOUR ATTORNEY-IN-FACT:

   a. Your attending physician;

   b. An employee of the attending physician unless he/she is related to you by blood, marriage or adoption;

   c. The owner, operator or employee of a health facility where you are a patient unless the person is related to you by blood, marriage or adoption.

3. Initial the box on either line 11 or line 16:

   a. Initialing at line 11 to limit this power of attorney to health care decisions at Southwest Washington Medical Center including discharge decisions; or

   b. Initialing at line 16 to grant unlimited authority to your attorney-in-fact regarding health care decisions. Do not initial **both** lines 11 and 16.

4. If you have specific instructions to or limitations on the power of the attorney-in-fact, place them on lines 27-29.

5. You may give your attorney-in-fact the power to decide whether to withhold or withdraw life sustaining procedures which may result in your death by initialing the box at line 35.

   You may give your attorney-in-fact the power to decide whether to withhold or withdraw artificially administered hydration or nutrition which may result in your death by initialing the box at line 40.

6. The law in the state of Washington is unclear concerning the authority of a person with a power of attorney to decide whether to withhold or withdraw artificially administered hydration (liquids) or nutrition or both, which may result in your death. Nevertheless, it is important to make your wishes known, as the law may be clarified at any time.

7. Sign and date the form on lines 44 and 47.

8. You should give a copy of the form to your health care provider who will make it a part of your medical record. You should bring a copy with you each time you are admitted to a hospital.

9. If you wish advice or have questions regarding a Power of Attorney for Health Care, you are urged to contact your lawyer.

WARNING TO PERSON APPOINTING A POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document. It creates a power of attorney for health care. Before signing this document, you should know these important facts:

This document gives the person you designate as your attorney-in-fact the power to make health care decisions for you, subject to any limitations, specifications or statement of your desires that you include in this document.

The person you designate in this document has a duty to act consistently with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in a manner consistent with what the person in good faith believes to be in your best interest. The person you designate in this document, does, however, have the right to withdraw from this duty at any time.

You have the right to revoke the appointment of the person designated in this document by notifying that person or your health care provider of the revocation orally or in writing.

Despite this document, you have the right to make medical and other health care decisions for yourself as long as you are able to participate knowledgeably in those decisions.

If you wish advice regarding your signing of this document, or if you have any questions, we urge you to consult with a lawyer of your choice,

POWER OF ATTORNEY FOR HEALTH CARE

I, _____ , being of sound mind, willfully and voluntarily, appoint _____ , whose address is _____ _____ ,and whose telephone number is _____ , as my attorney-in-fact for health care decisions. This power of attorney shall become effective only upon my disability, as determined by a physician.

The authority granted is as follows:

INITIALS	This power of attorney is limited to health care decisions arising during the course of my treatment at any time at Southwest Washington Medical Center and to making appropriate arrangements for my discharge from the Medical Center;

- OR –

INITIALS	This power of attorney extends to **all** health care decisions regarding my care.

I have read the warning which accompanies this form and understand the consequences of appointing a power of attorney for health care. I understand that, under Washington law, my attorney-in-fact cannot consent to the following procedures; (a) therapy or other procedure which induces convulsion; (b) surgery solely for the purpose of psychosurgery; (c) amputation; and (d) other psychiatric or mental health procedures which are intrusive on a person's bodily integrity or physical freedom of movement.

I direct that my attorney-in-fact comply with the following instructions or limitations;

_____

_____

In addition, I direct that my attorney-in-fact shall have authority to make decisions regarding the following:

INITIALS	Withholding or withdrawal of life-sustaining procedures with the Understanding that death may result.

INITIALS	Withholding or withdrawal of artificially administered hydration or nutrition or both with the understanding that dehydration, malnutrition , and death may result.

_____

Signature of person making appointment

_____

Date