ADVANCED HEALTH CARE DIRECTIVE

I, [PRINT NAME] _____ , having the capacity to make health decisions, willfully and and voluntarily state my wishes. I pray for a painless, blameless and peaceful death before God. It is my hope to be allowed to die naturally. I am an Orthodox Christian and my faith is very important to me. In the time of my affliction, it is my request that my family or physician contact my parish priest right away to attend to my spiritual needs. If he is not available, I request that a local priest from an Orthodox Christian jurisdiction recognized by the Assembly of Canonical Orthodox Bishops in the United States be contacted. I direct that if I am unable to communicate, I want my family and health care providers to do all that may be within their power to restore me, if there is a reasonable expectation for recovery. But if there is no probability of recovery, then I do not wish efforts to be taken to delay the separation of my soul from my body. Let it then be according to God's will. I further direct that my dying should not be prolonged under the circumstances set forth below:

If at any time I should have an incurable and irreversible condition certified to be a terminal condition by my attending physician, 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treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I may be permitted to die naturally. I understand ”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.

If I am diagnosed to be in a terminal or permanent unconscious condition,
[CHOOSE ONE] ☐ I want ☐ I do not want
artificially administered nutrition and hydration to be withdrawn or withheld the same as other forms of life-sustaining treatment. I understand artificially administered nutrition and hydration is a form of life-sustaining treatment in certain circumstances. I request all health care providers who care for me honor this directive.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family, physicians and other health care providers as the final expression of my fundamental right to refuse medical or surgical treatment, and also honored by any person appointed to make these decisions for me, whether by durable power of attorney or otherwise. I accept the consequences of such refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I also understand that I may amend or revoke this

directive at any time.

I make the following additional directions regarding my care:

_____

_____

_____

I have created a separate Health Care Power of Attorney ☐ YES ☐ NO

_____ _____
DECLARANT SIGNATURE DATE

**********FOR NOTARY PUBLIC**********

STATE OF WASHINGTON, COUNTY OF _____

On this day personally appeared before me _____ , to me known and the individual described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her free and voluntary act and deed, for the uses and purposes therein mentioned.

Given under my hand and seal of office this _____ day of _____ 20____

_____
SIGNATURE

_____
NOTARY PUBLIC RESIDING AT

_____
PRINTED NAME

_____
MY COMMISSION EXPIRES:

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Revocation of Provision: I hereby revoke the above declaration of Health Directive on this _____ day of _____ , 20____

_____
DECLARANT SIGNATURE