Advance Health Care Directive
of WILLIAM D. HOOD

I, WILLIAM D. HOOD, 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:

I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

1. <u>Terminal Condition or Permanent Unconscious Condition</u>

1.1 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, then, in the absence of my ability to give directions regarding the use of life-sustaining treatment, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.

1.2 I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

1.3 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.

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2. Severe and Permanent Mental and Physical Deterioration

There are certain qualities of life that I would consider worse than death, and in which I would want to be allowed to die naturally. If my physician and my Health Care Agent believe that I suffer from severe and permanent mental and physical deterioration, such that my quality of life has been significantly diminished, and my physician further certifies that my mental and physical deterioration is permanent and not likely to meaningfully improve over time, then, in the absence of my ability to give directions regarding the use of life-sustaining treatment, and where the application of life-sustaining treatment would only serve 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 may complete and attach an additional statement of the types of conditions that I would consider worse than death, and in which I would want to be allowed to die naturally. If I have not done so, I want my Health Care Agent to use his or her best judgment based upon any conversations we have had, or other expressions of my wishes and values.

3. Life-Sustaining Treatments I Do Not Want

If I am diagnosed to be in a terminal condition or in a permanent unconscious condition, or if it is determined that I suffer from severe and permanent mental and physical deterioration, such that my quality of life has been significantly diminished, then I do not want these life-sustaining treatments started, and, if already in use, I want them stopped : (Initial)

[initials] If my heart or breathing stops, I do not want CPR/measures to try to restart my heart or breathing.

[initials] If I cannot breathe on my own, I do not want artificial ventilation.

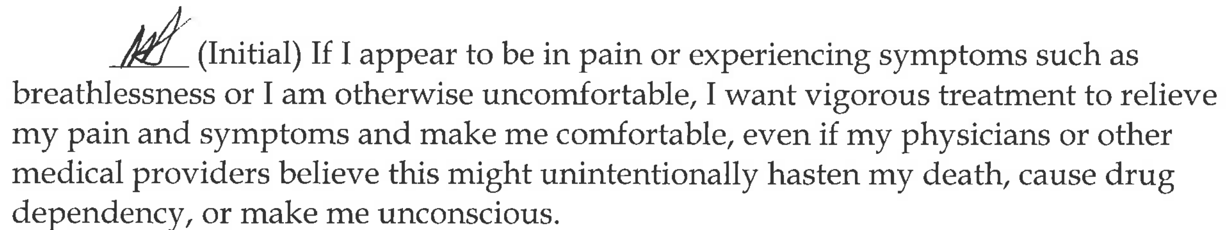
[initials] If I cannot eat and drink enough to sustain myself, I do not want artificial nutrition and hydration.

I further direct my Health Care Agent to use his or her best judgment, considering all of the circumstances, to make decisions regarding all life-sustaining treatments, including those initialed above, as well as surgeries to prolong my life, blood dialysis or filtration to clean life-threatening substances from my blood, transfusion of blood, plasma, blood products or replacement fluids, medications, when

their purpose is to prolong life rather than control pain or make me comfortable (for example, antibiotics, chemotherapy, steroids, medicines to make my heart work, and insulin), and anything else intended to keep me alive.

4. <u>My Wishes Concerning Comfort Care and Pain Medication</u>

Notwithstanding the foregoing direction regarding artificial hydration, by this Directive I do not mean to preclude the use of pain medication or other treatment to make me comfortable or alleviate pain.



_____ (Initial) If I appear to be in pain or experiencing symptoms such as breathlessness or I am otherwise uncomfortable, I want vigorous treatment to relieve my pain and symptoms and make me comfortable, even if my physicians or other medical providers believe this might unintentionally hasten my death, cause drug dependency, or make me unconscious.

5. <u>Special Considerations Regarding Notice and Surgery</u>

5.1 Notwithstanding anything in this instrument to the contrary, if it is possible, I would like my immediate family to be given reasonable notice and time to visit, before any treatment is withheld or withdrawn.

5.2 If I have authorized a specific surgical procedure, then I also authorize my health care professionals to make all efforts to keep me alive and provide life-sustaining treatment during any authorized surgery.

6. <u>Health Care Directive to be Honored</u>

In the absence of my ability to give directions regarding the use of 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, that person shall be guided by this Directive and any other clear expressions of my desires.

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7. Disputes, Family Involvement, and Conflicts

7.1 In the event of any dispute, the person named as my Health Care Agent shall be authorized to make a final and binding decision. It is also my intent that my Health Care Agent be allowed to exercise discretion in any of the above situations, and make the decision that he or she feels that I would have made, had I been able to comprehend all of the circumstances.

7.2 In implementing this Health Care Directive, my Health Care Agent is encouraged but not required to consult with my spouse, children, step-children, adult grandchildren, siblings and parents, unless I have specifically excluded their participation in my affairs under this document or under any other writing made by me.

7.3 Should any person or institution not honor my wishes, I authorize my Health Care Agent to move me to a place where my requests will be honored, and if necessary, to initiate litigation to protect and enforce my rights.

7.4 If I have previously executed a Health Care Directive, I hereby revoke any such document. This Health Care Directive is the only valid Directive executed by me at this time. If I subsequently execute a Health Care Directive, then that new Health Care Directive shall automatically revoke this Health Care Directive. If I contemporaneously or subsequently execute a POLST form (Physician's Orders for Life-Sustaining Treatment), then that POLST form shall supplement but not revoke this Health Care Directive.

8. Capacity to Execute Health Care Directive

I understand the full import of this Directive and I am emotionally and mentally capable to make the health care decision contained in this Directive.

9. Change to the Legislatively Approved Health Care Directive

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.

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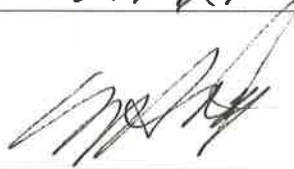
10. Validity

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.

DATED this 4 day of November, 2021.



WILLIAM D. HOOD
Domiciled and Residing in Seattle,
King County, Washington

STATE OF WASHINGTON)
) ss.
COUNTY OF KING)

This is to certify that on this date, WILLIAM D. HOOD personally appeared before me, the undersigned Notary Public, to me known to be the person described in and who executed the foregoing Advance Health Care Directive and acknowledged to me that he signed and sealed the same as his voluntary act and deed, for the uses and purposes therein mentioned.

SUBSCRIBED AND SWORN to before me this 4 day of November, 2021.

ELIZABETH F. JENNINGS
NOTARY PUBLIC in and for the State of Washington, residing at Lynnwood, WA
My commission expires March 11, 2024

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