INSTRUCTIONS FOR OBTAINING A WILL.

1. Complete the attached the Will worksheet to the best of your ability prior to your appointment.

2. The attorney must interview each person before the Will is prepared. If both you and your spouse need a Will, you may be seen together so long as you both have seen and discussed each other's worksheets, and agree on the contents. Also please review and sign the letter at Appendix A to the worksheet *(Dual Representation Authorization)*.

3. Please bring the following documents with you for your appointment:

   a. A completed Will worksheet. *(A separate worksheet is needed for the preparation of each person's Will.)*
   b. A **copy** of your current Will, if possible *(for reference purposes only)*, and other documents called for by the worksheet. Please avoid bringing any existing, original Will and do not mark on it in any case, because doing so could invalidate it.
   c. A list of any questions you may have for the attorney.

4. During your appointment, the attorney will review the Will worksheet with you and answer any questions that you may have. We will prepare a draft copy of your Will after meeting with you, you can review it and then the attorney will finalize it.

5. The final step is signing your Will. The Will signing session requires certain formalities, including a review of the documents, the actual signing of the Will, the witnessing of such signatures, and a final briefing, all of which, include preparation of the Will and ancillary documents, can be time consuming.

6. You must bring a legal form or photo identification *(state driver's license, military identification card, passport, e.g.)* with you to all appointments. This is necessary to verify your identity for our notary public and to determine eligibility for legal assistance.

Your cooperation is important and allows us to provide you the best in legal assistance. Please let us know how we may better serve your needs. To help you, we have included some definitions of some terms used in estate planning.

Teresa Ann Neudorfer
Attorney at Law

329 S. Third
P.O. Box 2018

(360) 683-7295
Sequim, Washington 98382

WILL TERMINOLOGY

WHAT IS A WILL? A Will is a legally effective declaration of a person's wishes as to the disposition of property upon his/her death. It must be executed with the formalities required by Washington state statute. The provisions of a Will do not take effect until after the death of the maker. A Will never disposes of the proceeds of insurance policies with named beneficiaries, nor does it dispose of some items of property that are held under various forms of special ownership, such as joint tenancy with a right of survivorship, or tenancy by entirety. In a Will, you will designate a Personal Representative *(see definitions below)*. It is important that you contact the prospective Personal Representative prior to the preparation and execution of the Will to ensure that they are willing to accept the position.

WHO IS THE BENEFICIARY? Anyone to whom the maker of a Will *(testator/trix)* leaves a portion of property.

WHAT DOES BEQUEATH MEAN IN A WILL? To give personal property by Will.

WHAT IS A BOND? Money put up by an executor to insure against loss occasioned by their negligence or theft.

WHAT IS DOMICILE? Your permanent home *(sometimes referred to as state of legal residence)*. The place to which, whenever you are absent, you have the intention of returning. You can have more than one residence, but you can only have one domicile. Your intent, voting, paying taxes, registering automobiles, obtaining a driver's license, and location of assets are factors considered in determining domicile. If Washington is not your state of legal residence, we recommend you contact an attorney in that state, as state laws and regulations can vary.

WHAT IS AN ESTATE? All property, real and personal, in which a person has an interest, such as money, savings accounts, stocks, house, furniture, insurance policies, etc.

WHAT DOES RESIDUARY ESTATE MEAN? Residuary is a derivative of the word "residue." It means what is left over. Your residuary estate is the portion of your estate that is left over when everything else is disposed of.

WHAT DOES EXECUTION MEAN? To validate a Will by correctly signing it and having it witnessed.

WHO IS THE PERSONAL REPRESENTATIVE? The person named in a Will to carry out the wishes expressed in the Will. An Executor is male; an Executrix is female. Upon the death of a maker of a Will, the Personal Representative must take the Will to the proper Court for

probate. Once the Court accepts the Will as valid, the Court officially appoints the person as Personal Representative. A Personal Representative may be entitled to compensation for their services. Individuals serving in this capacity serve subject to Court approval. While most courts follow the desires of the Testator/trix in the Will, they are not bound to do so. A bond may be required of a Personal Representative.

WHO IS THE TESTATOR/TRIX? You, the person making the Will. A Testator is male; a Testatrix is female.

WHAT IS PERSONAL AND TANGIBLE PROPETY? Property that is moveable.

WHAT IS A PROBATE? A Court proceeding where the Personal Representative seeks to establish a Will as genuine, settle all the debts of an estate and distribute the property in the estate to the heirs according to the wishes of the Will maker as expressed in the Will.

WHAT IS A PROBATE ESTATE? The portion of an estate that requires Court supervised administration to effect transfer of title. It does not include property transferred at the time of a person's death by other means, such as property held as joint tenants with right of survivorship, or life insurance paid to a designated beneficiary. For tax purposes, all property which the decedent owned or had an interest, may be included in the taxable estate, although some of it is not within the probate estate.

WHAT IS REAL PROPERTY? Property that has a fixed location, such as land or a house.

With these terms in mind, let's begin . . .

POWER OF ATTORNEY FOR HEALTH CARE

Another important health care document is the special power of attorney for medical care. You may execute this document in addition to, or in lieu of the living Will.

This document appoints someone to make medical care decisions for you in the event that you cannot make your own medical decisions. It applies to make more situations than the Living Will, which addresses only the issue of continued life support if you have a terminal condition. The power of attorney for medical care gives the person you designate as your agent the authority to make a wide range of medical decisions on your behalf. It also gives your agent access to your medial information and authority to fully participate with your treating physicians in deciding the care to be provided to you. Obviously, the person you designate to be your agent should be someone you trust with life and death decisions. Like the living will, the power of attorney is usually drafted in accordance with the laws of the state where you are residing.

Do you want a special **Power of Attorney for Health Care** decisions? ___ Yes ___ No

Do you want to include this **Power of Attorney for Health Care** decisions with the **Power of Attorney** discussed on the next page? ___Yes ___ No

For You	For Spouse
1st Choice:	1st Choice:
Full Name (First, Middle, Last)	Full Name (First, Middle, Last)
Address:	Address:
Phone number:	Phone Number:
2nd Choice	2nd Choice
Full Name (First, Middle, Last)	Full Name (First, Middle, Last)
Address:	Address:
Phone number:	Phone Number:

IF YOU WANT A POWER OF ATTORNEY, COMPLETE THIS SECTION:

The person whom you name in a Power of Attorney to handle your affairs on your behalf is called an Attorney-in-Fact. You may provide this person with broad or limited powers. Please list below the types of authority or powers you wish your Attorney-in-Fact to have:

	YES	NO
1. Authority to dispose of real property	_____	_____
2. Authority to dispose of personal and intangible property	_____	_____
3. Authority to access bank accounts and safety deposit boxes	_____	_____
4. Authority to make contracts on your behalf.	_____	_____
5. Authority to execute and file tax returns	_____	_____
6. Authority to carry out all business transaction	_____	_____
7. General authority with respect to all other matters	_____	_____
8. Authority over Health Care (as discussed on the previous page).	_____	_____

Specifically list any other authority which you wish your Attorney-in-Fact to have:

_____

_____

Name, address, telephone number and relationship to you of the person whom you propose to name as an Attorney-in-Fact:

Do you want the same people as on the previous page? ___ Yes ___ No

If "No," please fill in the following:

1st Choice	2nd Choice
Name	Name
Address	Address
Phone	Phone
Relationship	Relationship

Please select A or B below, whichever best reflects your wishes:

A. This Power of Attorney shall take effect immediately.

OR

B. This Power of Attorney shall take effect only if I become incapable of managing my own affairs (if Health Care powers are given, those powers will be effective

immediately, since they may need to be exercised before your disability can be evidenced by a doctor).

You may in this document nominate a future guardian to serve in the event you become incapable of managing your affairs and a court determines that a guardianship is necessary. Do you wish the person whom you have selected as your Power of Attorney also to be your choice should a guardianship be necessary? ___ Yes ___ No

That's it, except spouses who wish to be seen together must reads and sign the attached letter at **Appendix A (Dual Representation Authorization)**. We look forward to meeting with you soon.

PERSONAL INFORMATION

DATE: _____

1. Marital Status (check all that apply)	__ Married	__ Single	__ Widowed	__ Divorced __ Separated or about to divorce
2. Your Name (First, Middle, Last)	Soc. Sec. No.			Date of Birth
3. Spouse's Name (First, Middle, Last)	Soc. Sec. No.			Date of Birth
4. Home Address (Number, Street)	City		State	Zip
5. Home Phone ( )	Work/Cell Phone ( )		Spouse's Work Phone ( )	
6. Have you served in the Armed Forces? (you may be entitled to certain benefits upon death)	Svcmbr's Rate/Rank	Branch of Service		Time in Svc
7. Did your spouse serve in the Armed Forces?	Spouse's Rate/Rank	Branch of Service		Time in Svc

Circle or fill in your answers	You	Your Spouse
8. Are you a U.S. citizen?	Yes No	Yes No
9. Do you have a Will or Trust now? **	Yes No	Yes No
10. Are you expecting to receive property or money from (circle all that apply): If so, approximately how much:	Gift inheritance Lawsuit – Other $	Gift inheritance Lawsuit – Other $
11. How many natural children do you have (you are the biological parent)?		
12. How many adopted children do you have?		
13. How many stepchildren do you have (not adopted)?		
14. Domicile/state of legal residence?		
15. Have you ever lived in another Community Property State? (AZ, CA, ID, LA, NV, TX, WA, WI, PR)	Yes No	Yes No
16. Do you have a pre-nuptial or post-nuptial agreement? **	Yes No	Yes No
17. Do you have a divorce decree that mentions pension, insurance or other property rights? **	Yes No	Yes No
****If "yes" to questions 9, 16 or 17, you must bring these documents to your appointment.**		

YOUR ESTATE ASSETS

To determine what type of Will is appropriate for you, you need to provide a rough estimate of the value of your estate. For this purpose, include the value of all of the property you own in your name, and if married, the value of your spouse's property. If any of your property secures a debt (for example, a mortgage on your home), include your equity in the property. Also include the value of your life insurance policies. Note that life insurance ordinarily does not pass according to your Will; it will go to the beneficiaries you designated on the insurance forms. However, the value of the insurance is typically included in determining whether estate taxes will apply in your case.

You may not have some of the types of assets listed below. If not, just print "NONE" in the spaces and move on. If you need more room to write additional assets, please write on a separate piece of paper.

18. Do you (or your spouse) have any **COMMERCIAL** life insurance policies and/or annuities?

Name of Company	Who is Insured	Who owns the Policy	1st Beneficiary	2nd Beneficiary	Death Benefit
Value of your life insurance			Total Value of Policies in Question		

19. Do your (or your spouse) own any other titled property such as a car, boat, etc.

Description and Location	Titled in whose name (or names) Indicate if Joint or Beneficiary and name	Purchase Price	Market Value	(-) Mortgage)	(=) Equity
				Total Net Value:	

20. Do you (or your spouse) own any other titled property such as a car, boat, etc.?

Description	Titled in whose name (or names) Indicate if Joint or Beneficiary and name Market Value	Market Value	(-) Loan	(+) Equity
			Total Net Value:	

21. Do you (or your spouse) have any checking accounts or interest bearing accounts (savings, money market, CD's)

Name of Bank and type of account (savings, checking, etc.)	Titled in whose name (or names) Indicate if Joint or Beneficiary and name	Approx. Balance
	Total Value:	

22. Do you (or your spouse) own any investments such as stocks or mutual funds (do not include ITAs)?

Name of Investment or Brokerage Account	Titled in whose name Indicate if Joint or Beneficiary and name	Current Value
	Total Value:	

23. Do you (or your spouse) have any profit sharing, IRAs or pension plans?

IRA/Plan Owner (H or W) Description of Plan or IRA	Who is designated as beneficiary if owner dies?	Current Value
	Total Value:	

24. Does anyone owe you money? If yes, please describe the loan(s) and approximate value on a separate piece of paper.

25. Do you own a business or any special items of value such as coin collections, antiques, jewelry, etc.? If yes, describe the business plan, and/or other items and their approximate value on a separate piece of paper.

YOUR PLAN OF DISTRIBUTION

In the following section you will tell us how you want your property distributed at your death. If you need more room, please use an additional piece of paper. **REMEMBER: If you and your spouse do not want the same distribution plan, then you will need to fill out SEPARATE forms. This form is designed for couples who desire the same plan.**

SPECIFIC BEQUESTS: You may elect to make specific gifts of cash, real estate, or personal property to specific people or charities in your Will. However, these bequests will be distributed first and may deplete your estate. Also, specific bequests may complicate the probate of your estate if the property given cannot be found at your death. Therefore, if you make any specific bequests, you should only give property or amounts of cash that you are reasonably sure you will possess at the time of your death. If you make no specific bequests, all of your property will pass to your primary beneficiaries.

26. Special Gifts to Children, Family, Friends or Other Individuals (for example: wedding ring to your daughter)

Name of Person & Relationship	Dollar Amount or Accurate Description of Gift	Alternate Beneficiary (if any)

27. Special Gifts to Organizations (a charity, foundation, religious or fraternal organization

Complete Legal Name of Organization and Address	Dollar Amount or Accurate Description of Gift	Alternate Beneficiary (if any)

28. Distributing the Rest (Residuary): The residuary estate is whatever property remains in your estate after debts and expenses of administration have been paid, and any specific bequests have been paid. Because many people do not make specific bequests, "residuary estate" usually describes all the property that you will leave to your beneficiaries.

____ check here if you want your spouse to get all, and if your spouse dies, then equally to your children.

If you do not check the box above, please complete the grid below.

Name of Person (First, Middle, Last) or Organization	Relationship	Percentage (must add to 100%))

29. Alternate Beneficiaries

Who do you want to receive your estate if you (and your spouse) outlive the beneficiaries you've named above?

Name of Person (First, Middle, Last) or Organization	Relationship	Percentage (must add to 100%))

If one of your children dies, do you want that child's share to go to the child's children, your grandchildren (per stirpes) ____, or do you want that child's share to be divided among your remaining living children, with ***nothing*** going to a grandchild whose parent died (per capita) ___?

30. Disinheriting

Are there any relatives that you specifically do not want to receive anything from your estate? List names and relationship:

(a) _____;

(b) _____;

(c) _____.

CHOOSING THE PEOPLE THAT TAKE CARE OF YOUR AFFAIRS AFTER YOUR DEATH

31. Personal Representative: The personal representative is the person who makes sure your estate is settled upon your death. This ordinarily involves going through probate, which is a court-administered procedure for settling an estate. Probate involves petitioning a Court for letters of appointment or testamentary, settling creditor claims, finding and distributing assets, and filing any necessary tax returns. Any adult may serve as your personal representative, although it may be an easier process if your personal representative is a legal resident of the state where probate is conducted. Therefore, if possible, you should select family members or responsible friends who are residents of the same state you claim as your legal residence or the state where you own real estate.

In Your Will	In Your Spouse's Will
Full Name:	Full Name:
Relationship	Relationship
Address:	Address:

32. Successor Personal Representative: Back-up manager that takes over if your first personal representative dies or resigns. Same restrictions as above.

In Your Will – 1st Successor	In Your Spouse's Will – 1st Successor
Full Name:	Full Name:
Relationship	Relationship
Address:	Address:
In Your Will – 2nd Successor	In Your Spouse's Will – 2nd Successor
Full Name:	Full Name:
Relationship	Relationship
Address:	Address:

33. Must the personal representative be bonded or insured to protect your beneficiaries (the insurance or bond will be paid with funds from your estate?

___ Yes ___ No

34. YOUR CHILDREN

Full Name (First, Middle, Last)	Age	T= From this Marr. P=Previous Marriage If P, whose? H or W	Child Married? Y or N	Number of Grandchildren

35. If you have step-children, do you want your Will to state that they are to be treated under your Will like natural born children?

___ Yes ___ No

36. If you have children from a previous marriage, do you want to guarantee they receive an inheritance from you?

___ Yes ___ No

ADVANCED MEDICAL DIRECTIVES AND POWERS OF ATTORNEY
(A Living Will)

By executing a Living Will, you will be stating your desire to have or not to have life-prolonging procedures such as artificial respirators, surgeries, radiation and other treatments which may delay but do not prevent imminent death or artificially provided nutrition and hydration. This document only takes effect if you have been diagnosed with a terminal illness or become permanently unconscious and your doctor has certified that death will occur within a short period of time.

Please check below which best reflects your wishes if your doctor has certified that death will occur within a short period of time.

LIFE-PROLONGING TREATMENT:

___ I **DIRECT THAT LIFE-PROLONGING TREATMENT BE WITHHELD OR WITHDRAWN**, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

___ I **DO NOT AUTHORIZE** that life-prolonging treatment be withheld or withdrawn.

ARTIFICIALLY PROVIDED NUTRITION AND HYDRATION:

___ I **AUTHORIZE WITHHOLDING OR WITHDRAWAL** of artificially provided food, water or other artificially provided nourishment or fluids.

___ I **DO NOT AUTHORIZE** the withholding or withdrawal of artificial food, water or other artificially provided nourishment or fluids.

___ I **AUTHORIZE MY SURROGATE, PREVIOUSLY DESIGNSTED, TO WITHHOLD OR WITHDRAW** artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

DONATION OF BODY:

___ I **AUTHORIZE** the giving of all or any part of my body upon death for medical research.

___ I **DO NOT AUTHORIZE** the giving of all or any part of my body upon death.

Other Concerns:

After recording return to:

_____
_____
_____
_____

Durable Power of Attorney

Grantor: _____

Grantee: _____ and/or _____

I, _____, a resident of the State of Washington, hereby revoke all powers of attorney I have previously granted and give _____ (referred to below as the "attorney-in-fact"), a durable power of attorney, with the intention that it shall remain in effect and not be limited by any future disability or incompetence I may have. In the event that _____ is unable or unwilling to serve as the attorney-in-fact, I appoint _____, as my successor attorney-in-fact. The successor attorney-in-fact shall have all the duties, rights and responsibilities of the original attorney-in-fact.

1. POWERS

A. The attorney-in-fact shall act as a fiduciary for me and shall have all powers over my estate that I have or acquire, both within and outside of Washington and all powers granted to Trustees by RCW 11.98.070 and any amendments thereto. These powers shall include , but not be limited to, the following:

(1) The power to take all actions regarding all of my banking and investment affairs, including transactions with any financial or investment institution and to control, deal with, open and close, make deposits to and payments from bank accounts, investment accounts, deposits and certificates, including individual retirement accounts and other retirement arrangements, in which I am named or have any interest;

(2) The power to open and remove items from any safe deposit box in my name, unless a contrary provision is in the safe deposit agreement;

(3) The power to purchase, sell, exchange or transfer title to stocks, bonds, commodities or other securities and receive, approve and confirm all related notices and demands of any sort intended for me;

(4) The power to liquidate, annuitize or elect distributions from any life insurance or annuity policy that I may own;

(5) The power to sell, convey, purchase, lease, assign, exchange or encumber any real or personal property that I own or in which I have an interest;

(6) The power to disclaim any interest, as defined in RCW 11.86.011;

(7) The power to make all decisions requisite for the conduct of or termination of any business, profession or employment in which I am engaged, including decisions as to retirement, disability, other benefits, continuation of salary, receipt or disposition of business shares and all other matters relating to my business or employment;

(8) The power to act for me and represent me in all tax matters, including the preparation, signing and filing of any state or federal tax returns, or extensions thereof. The attorney-in-fact may represent me in any tax audit, appeal, controversy, or court action involving any state or federal tax return filed on my behalf and pay any assessments for interest or penalties levied against me in connection with such tax return;

(9) The power to enter into contracts on my behalf;

(10) My Attorney-in-Fact shall have authority to execute care contracts with care providers to provide for the care of the Principal, either in a residential or institutional setting, specifically including care in the home of the Principal or in the home of the Attorney in Fact, care in an Adult Family Home, Congregate Care Facility, Boarding Home, or Skilled Nursing Facility. This power specifically includes the authority to enter into a contract for care between the Principal and the Attorney-in-Fact for care provided by the Attorney-in-Fact or members of the family of the Attorney-in-Fact or in the home of the Attorney-in-Fact or in the home of Principal at commercially reasonable rates for similar services provided in similar settings. My Attorney-in-Fact shall have authority to hire professional case managers, medical staff, legal counsel and others to assist the Attorney-in-Fact relative to the provision of care, placement and other decisions and use the resources of the Principal to pay for such services.

NO POWER TO AGREE TO BINDING PRE-DISPUTE ARBITRATION AGREEMENTS

Although I have given my agent authority to make placement decisions and to execute agreements for care in this Durable Power of Attorney, I specifically *withhold* the power to agree to binding arbitration prior to the actual occurrence of an injury or controversy, or to agree in advance to any other process that would preclude any right to have a jury decide an issue concerning my person or property, or to limit in advance any rights to litigate potential claims for damages. This does not preclude agreeing to non-binding alternative dispute resolution processes, such as mediation, nor does it preclude submitting a dispute after it has occurred to binding arbitration following the advice of counsel to my agent.

(11) The power to pay, settle, compromise or otherwise discharge any debts, claims or liabilities asserted against me;

(12) The power to request, recover, sue for and receive any money, gifts, or assets due to me;

(13) The power to participate in any legal action on my behalf;

(14) The power to deal with all of my estate or trust matters where I am a beneficiary and make all elections permissible in relation thereof;

(15) The power to apply for and receive on my behalf insurance, social security, pension, disability, annuity, medical, Medicare, Medicaid, Veterans or any other medical or income benefit, either private or governmental, to which I may be eligible;

(16) The power to sign on my behalf an intention to return home when applying for Medicaid long-term-care benefits;

(17) The power to make transfers of the principal's property, both real and personal, to any trust created by the principal of which the principal is the primary beneficiary during the principal's lifetime;

(18) The power to establish a Trust and to make transfers of principal's property, both real and personal, to such Trust;

(19) The power to make gifts, whether outright or in trust in such amounts as the attorney-in-fact shall determine appropriate so long as such gifts would be in my best interests and those interested in my estate, such determination to be made in the sole discretion of the attorney-in-fact;

(20) The power to make transfers of my property, including gifts or to a Trust for the purpose of qualifying for governmental medical assistance or long-term care coverage, or to avoid estate recovery related to such assistance or coverage, to the full extent provided by law should there be an actual or

anticipated need for medical care or long-term care. Any transfers made pursuant to this paragraph shall be deemed not to be a breach of fiduciary duty by the attorney-in-fact.

B. The attorney-in-fact shall not have the power to revoke or change any life insurance beneficiary designations or any estate planning or testamentary documents previously executed by me, except as deemed reasonable and appropriate by my attorney-in-fact for the purpose of preserving my estate from the cost of long-term care or from any claims against my estate by any entity which has provided me with coverage for medical or long-term care services, provided that any such changes made by my attorney-in-fact shall be reasonably consistent with my previously executed estate plan. My attorney-in-fact shall have the power to revoke any community property agreement executed by me.

C. Notwithstanding any of the foregoing, the attorney-in-fact shall be authorized to make transfers of any property or to exercise any of the foregoing powers only (i) for the purpose of qualifying the principal or the principal's spouse for governmental medical assistance or long-term care coverage, or to avoid estate recovery related to such assistance, or (ii) of the transfer constitutes an excludable gift under applicable federal gift and estate tax law.

D. It is my intention that if I require long term care services and if a divorce would preserve my and my spouse's estate from the costs of long term care services, I specifically authorize my attorney-in-fact, or guardian if necessary, to proceed on my behalf with a divorce and to agree to a property settlement whereby my spouse receives all of my community and separate property so that I may qualify for Medicaid services as soon as possible.

E. The attorney-in-fact shall have all powers over my person necessary or desirable to provide for my support, maintenance, health, education or comfort.

2. EFFECTIVE DATE

This Power of attorney shall become effective upon and only during, any period of incapacity in which, in the opinion of the attorney-in-fact and the attending physician, I am unable to make or communicate a choice regarding my personal, financial or legal affairs.

3. DURATION, REVOCATION AND TERMINATION

Notwithstanding any uncertainty as to whether I am alive or dead, this power of attorney shall continue in effect, to the extent permitted by law, until revoked or terminated. I may revoke this power of attorney by giving written notice to the attorney-in-fact and, if this power of attorney is recorded in any county, by recording the written instrument of revocation in the office of the recorder or auditor of any such county in which this power of attorney is recorded. This power of attorney shall be terminated upon receipt of written notice or actual knowledge by the attorney-in-fact, of my death; and further

may be terminated by the guardian of my estate following court approval of such termination.

4. RIGHTS AND DUTIES OF THE ATTORNEY-IN-FACT

A. Reliance. The attorney-in-fact and all persons dealing with the attorney-in-fact shall be entitled to rely upon this power of attorney so long as it is effective and has not been revoked. Any action taken in reliance on this document, unless otherwise invalid or unenforceable, shall be binding on my heirs, devisees, legatees or personal representatives.

B. Indemnity. My estate shall hold harmless and indemnify the attorney-in-fact from all liability for acts done for me in good faith based on this power of attorney.

C. Accounting. My attorney-in-fact shall be required to account to any subsequently appointed personal representative.

D. Compensation. My attorney-in-fact shall be entitled to reasonable fees for services rendered as my attorney-in-fact, such services to be documented in writing.

E. Petition to the Court. Pursuant to RCW 11.94.100, any interested person may petition the court for an order to (i) compel an accounting; (ii) require the attorney-in-fact to exercise or refrain from exercising authority in a particular manner or for a particular purpose; (iii) remove the attorney-in-fact; or (iv) require the furnishing of a bond. If the interested person demonstrates to the court's satisfaction, that the person is interested in the welfare of the principal and has a good faith belief that the court's intervention is necessary and the Principal is unable to protect his or her own interests, the court may grant the relief requested.

F. Engagement of Counsel. Any person serving as attorney-in-fact under this durable power of attorney may engage the same legal counsel as Principal has used and the Principal by signing below waives any conflict of interest that may be asserted against the use of the same legal counsel.

5. NOMINATION OF GUARDIAN

I nominate the attorney-in-fact for consideration by the court as my guardian or limited guardian in the event that any guardianship proceeding for my person or estate should be commenced. It is my intention that the powers given to the attorney-in-fact designated herein be so broad as to obviate the need for the appointment of a guardian or limited guardian of the person or estate.

6. HEALTH CARE DECISIONS.

Effective Date. By separate document, I also intend to create a Durable Power of Attorney for Health Care and Health Care Directive effective upon and only during, any period of incapacity in which, in the opinion of the attorney-in-fact and the attending

physician, I am unable to make or communicate a choice regarding a particular health care decision.

7. APPLICABLE LAW.

The laws of the State of Washington shall govern this power of attorney.

Dated this _____ day of _____, 2017.

_____

_____

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

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

SUBSCRIBED and SWORN to before me this _____ day of_____, 2017.

_____
NOTARY PUBLIC in and for the State of Washington residing at Sequim.
My Commission expires: _____

DISCLOSURE STATEMENT

NOTICE AND WARNING to person executing this document --

This is an important legal document. Before executing this document you should know these important facts:

This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desire as stated in this document or otherwise made known. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

Your agent has the power to make a broad range of health care decisions for you. The person you appoint as your agent should be someone you know and trust. You should discuss this document with your agent.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desire and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. Your agent's authority begins when your doctor certifies that you lack the capacity to make health care decisions.

In addition, a court can take away the powers of your agent to make health care decisions for you if your agent authorizes anything that is illegal, or acts contrary to your known desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Unless you otherwise specify in this document, this document gives your agent the power after you die to donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and to direct the disposition of your remains.

This document revokes any prior durable power of attorney for health care.

It is important that you understand the range of decisions that may be made for you. If there is anything in this document that you do not understand, you should ask your attorney to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You also may want to give your doctor an executed copy of this document.

I have read and understand the content of the foregoing disclosure statement.

Dated: _____ _____

_____

WASHINGTON DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, appoint as my attorney-in-fact (hereafter referred to as "Agent") _____ to make any health care decision for me when, in the judgment of my attending physician, I am unable to make or communicate the decision myself and my agent consents to make or communicate the decision on my behalf.

My agent has the power to make any health care decision for me. This power includes the power to give consent, to refuse consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition, including giving me food or water by artificial means. My agent has the power, where consistent with the laws of Washington, to make a health care decision to withhold or stop health care necessary to keep me alive. It is my intention that my agent or any alternative agent has a personal obligation to me to make health care decisions for me consistent with my expressed wishes. I understand, however, that my agent or any alternative has no legal duty to act.

My agent and any alternate agents have consented to act as my agent. In the event that a proceeding is initiated to appoint a guardian of my person under RCW 11.88, I nominate my agent as my

choice to serve as my guardian. If my agent is unable or unwilling to act as my guardian, I nominate my alternate agent(s) to serve as my guardian.

My agent must act consistently with my desires as stated in this document or as otherwise made known by me to my agent.

My agent has the same right as I would have to receive, review and obtain copies of my medical records and to consent to disclosure of those records.

DESIGNATION OF ALTERNATE AGENT (OPTIONAL)

(You are not required to designate one or more alternate agents, but you may do so. An alternate agent may make the same health care decisions as your designated agent, if the designated agent is unable or unwilling to act as your agent.)

If my agent named by me shall die, become legally disabled, incapacitated or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as my alternate agent.

First Alternate Agent _____

SPECIAL INSTRUCTIONS (OPTIONAL)

(You may give your agent(s) any special instructions in this section. If you do not wish to do so, put "None" on the lines provided.)

NONE

LIMITATIONS (OPTIONAL)

(You may wish to put additional limitations on your agents in this section. If you do not wish to do so, put "None" on the lines provided.)

NONE

DURATION

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

OTHER PROVISIONS

By completing this document, I intend to create a Durable Power of Attorney for Health Care under Chapter 11.94 of the Revised Code of the State of Washington.

I revoke any prior Durable Power of Attorney for Health Care.

I understand that I may revoke this Durable Power of Attorney for Health Care at any time.

This Durable Power of Attorney for Health Care is intended to be valid in any jurisdiction in which it is presented.

This Durable Power of Attorney for Health Care shall become effective upon my disability or incapacity.

Photocopies of this Durable Power of Attorney for Health Care may be relied upon as though they were the originals.

SIGNATURE OF PRINCIPAL

I am fully informed as to all the contents of this Durable Power of Attorney for Health Care and understand the full import of this grant of power to my agent(s). I further declare that I am emotionally and mentally competent to make this Durable Power of Attorney for Health Care.

DATED this _____ day of _____, 2017.

_____

_____

STATE OF WASHINGTON)
) ss.
COUNTY OF CLALLAM)

On this _____ day of _____, 2017, before me, the undersigned, a Notary Public in and for the State of Washington personally appeared _____ (the Principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument; and acknowledged that he or she executed it as her voluntary act or deed.

I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence, and that I am satisfied as to the genuineness and due execution of this document.

_____
NOTARY PUBLIC in and for the State of Washington residing at _____
My Commission expires: _____

HEALTH CARE DIRECTIVE

Directive made this____ day of _____, 2017.

I, _____, having the capacity to make health care decisions, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged, and that I be able to die naturally under the circumstances set forth below, 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 or postpone 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 signing this directive that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, which 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 signing this directive 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 care, 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 person be guided by this directive and any other clear expression of my desires.

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

____ **I DO** want to have artificially provided hydration.

____ **I DO NOT** want to have artificially provided hydration.

____ **I DO** want to have artificially provided nutrition.

____ **I DO NOT** want to have artificially provided nutrition.

_____ **I DO** or _____ **DO NOT** want to have pain medication 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.

(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, delete from or revoke this directive at any time, and that any changes shall be consistent with Washington 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.

SUPPLEMENT TO HEALTH CARE DIRECTIVE

Pursuant to public policy declared in the Washington Natural Death Act (the "Act"), as amended, and to the authority granted in the Act to include other specific directions in the Health Care Directive set forth above, I declare and direct as follows:

Prior to taking any action under this Directive, _____, if competent, is to be consulted.

I have the capacity to make health care decisions and willfully and voluntarily make this Supplement. I do not intend that these additional specific directions revoke or in any way impair the effectiveness of any provision of the above Health Care Directive. I intend, however, that all provisions of the Act apply to this Supplement and to the persons, institutions, medical facilities, and personnel as fully and in all respects as they would if this Supplement were expressly authorized by the Act.

I request care that gives me comfort and support, that facilitates my interactions with those around me, and that relieves my pain and suffering. In case of severe pain, I request that drugs be administered to relieve pain, even if they may hasten the time of my death.

I ask that anyone making decisions under the Act regarding whether or not I am afflicted with a "terminal condition" or "permanent unconscious condition," and what constitutes a "life-sustaining treatment" give consideration to my desire that my dying not be prolonged through artificial means if I suffer from:

(a) unconsciousness from which I am not reasonably expected to recover, or

(b) irreversible physical brain damage or deterioration to the extent that I cannot interact with those around me.

I intend the following initialed statements to be included as part of this Directive, to be applicable if I am diagnosed to be in a terminal condition or in a permanent unconscious condition:

(a) _____ Because I cannot anticipate what ailment may afflict me in the future, I wish for my physician to advise my health care attorney-in-fact as to whether artificial nutrition and/or hydration will provide more comfort or less comfort and for my attorney-in-fact to exercise discretion to provide more comfort.

(b) _____ I DO want to receive antibiotic therapy or other treatment for reversible, secondary conditions.

(c) _____ I DO NOT want to receive antibiotic therapy or other treatment for reversible, secondary conditions, unless receipt of such therapy or treatment is needed to relieve pain or suffering.

Organ Donation: _____It is my desire that my organs be donated to a medical facility upon my death.

_____ It is **NOT** my desire that my organs be donated to a medical facility upon my death.

I intend that my family, my physicians and their medical assistants, my clergy, my lawyer, and any medical facility caring for me and its personnel cooperate with me and with each other in carrying out my directions and in allowing me to die with dignity. I have executed this Health Care Directive and Supplement in part to relieve them of feelings of guilt or of responsibility for my death that they might otherwise have.

This Health Care Directive supersedes all prior "Living Wills," "Directives to Physicians" or similar instruments I may have signed, and I hereby revoke such prior instruments.

Signed: _____

_____

Sequim, Clallam County, WA

Statement of Witnesses

Each of the undersigned witnesses makes the following statement:

1. I am not:

   a. related to person making the foregoing Health Care Directive (hereafter "Declarer") by blood, marriage or adoption;

   b. entitled to any portion of Declarer's estate upon the Declarer's death under any will or codicil now existing or by operation of existing law;

   c. Declarer's attending physician;

   d. an employee of Declarer's attending physician or a health facility in which Declarer is a patient; or

   e. a person who at this time has a claim against any portion of Declarer's estate upon Declarer's death.

2. Declarer is personally known to me, and I believe that the Declarer is capable of making health care decisions, and signed the foregoing Health Care Directive willfully and voluntarily.

3. I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Witness: _____ Witness _____

Printed Name_____ Printed Name_____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE OF:

_____

This document states my choices about use of life-sustaining medical treatment and comfort care. It is meant to inform and guide whoever will makes health care decisions for me, if I become unable to communicate.

1. WHEN I WANT THIS DOCUMENT TO APPLY

I want this document to apply if I become unable to make my own health care decisions.

I understand that such inability may only be temporary, and if I become unable to make certain decisions, I may still be able to make others. When I can make my own health care decisions I want to do so.

I want this directive to remain in effect after my death for autopsy, organ donation, and use of my body for medical research, and for my agent to arrange for the disposition of my remains, if I authorize that in Section 10.

2. MY HEALTH CARE AGENT

I appoint as my agent:

Name: _____
Address: _____
_____
_____
Telephone: _____
(day) (evening) (mobile)

My alternate agent:
If my agent is unable or unwilling to serve, or unavailable, or if my agent is a spouse or partner from whom I am separated or divorced when decisions need to be made for me, then I name this alternate agent:

Name: _____
Address: _____
_____
_____
Telephone: _____
(day) (evening) (mobile)

If my alternate agent acts for me because my first agent is unavailable, I intend that the alternate act only while my first agent is unavailable.

3. The Authority I Give My Agent

I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent and to contract for medical treatment recommended by my physicians, including life-sustaining treatments on my behalf as provided in RCW 11.94.010(3); (b) requesting particular medical treatments, dental care, nursing care, social service, assisted living or similar facility or service, including discharging such service; (c) accessing my medical records and information; (d) employing and dismissing health care providers; (e) changing my health care insurers; (f) making a Physician Orders for Life-Sustaining Treatment (POLST) form for me; (g) removing me from any health care facility to another facility, a private home, or other place. This release authority additionally applies to information governed by the Health Insurance Portability and Accountability Act of 1996, (HIPAA), as hereafter amended.

4. HOW TO MAKE HEALTH CARE DECISIONS FOR ME

I want whoever makes health care decisions for me to do as I would want in the circumstances, based on the choices I express in this document. If what I would want is not known, then I want decisions to be made in my best interest, based on (a) my values, (b) the contents of this document, and (c) medical information provided by my health care providers.

5. WHY I AM MAKING THIS DOCUMENT

I value life very much, but I believe that to be kept alive in certain circumstances is worse than death. I do not want others to substitute their choices for mine because they think their choices are in my best interest. I do not want my intentions to be rejected because someone thinks that if I had more information when I completed this document, or if I had known certain medical facts that developed later, I would change my mind.

____ I have accepted and attached an additional statement of my values. {Optional}

6. WHEN I DO NOT WANT LIFE-SUSTAINING TREATMENT

a. Qualities of life I consider worse than death, and in which I would want to be allowed to die: {initial all that apply}

___ (1) Unconsciousness or coma from which the ability to think or communicate will probably not be recovered, or, unconsciousness

____ lasting _____ week(s)

____ lasting _____ weeks(s) or doctor's judgment, whichever comes first.

____ doctor's judgment.

___ (2) Apparently complete or nearly complete loss of ability to think and communicate, which is probably permanent.

___ (3) Total dependence on others for my care because of physical deterioration, which is probably permanent.

___ (4) Pain which probably cannot be eliminated, or can be eliminated only by sedating me so heavily that I cannot converse.

___ (5) Irreversible dementia such as Alzheimer's disease.

___ (6) Other circumstances in which I would not want life-sustaining treatment:

_____

_____

_____.

b. Temporary use of life-sustaining treatment: I understand it is possible that I might experience an unacceptable quality of life – as initialed above or determined by my agent – at a time when my physician might believe temporary use of life-sustaining treatment would probably restore a quality of life acceptable to me. If so, then: {initial one]

___ (1) I want life-sustaining treatment,

____ for up to _____ week(s)

____ for up to _____ weeks(s) or doctor's judgment, whichever comes first.

____ doctor's judgment.

___ (2) I still do not want life-sustaining treatment.

7. LIFE SUSTAINING TREATMENTS I DO NOT WANT

If I experience a condition I initialed in 6.a or if I experience a quality of life my agent believes I would consider unacceptable, I do not want these life-sustaining treatments started, and, if already in use, I want them stopped (except for temporary use if I authorized that in 6.b.). {Initial all that you **do not want.**}

___ Nutrition other than ordinary food delivered by mouth, if I cannot eat enough to sustain myself.

___ Hydration other than ordinary water delivered by mouth, if I cannot drink enough to sustain myself.

___ All cardiopulmonary resuscitation (CPR) measures to try to restart my heart or breathing, if those stop, including artificial ventilation, stimulants, diuretics, heart regulating drugs, or any other treatment for heart failure.

___ Heart regulation drugs including electrolyte replacement, if my heartbeat becomes irregular.

___ Surgeries to prolong my life.

___ Blood dialysis or filtration to clean life-threatening substances from my blood, if my kidneys do not work normally.

___ Transfusions of blood, plasma, blood products, or other fluids to replace lost or diseased blood.

___ Medications, when their purpose is to prolong life rather than control paid (for example: antibiotics, chemotherapy, steroids, medicines to make my heart work, and insulin).

___ Anything else intended to keep me alive.

8. MY WISHES CONCERNING COMFORT CARE AND PAIN MEDICATION

	Yes	No
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.	____	____

9. REGARDING A HEALTH CARE INSTITUTION REFUSING TO HONOR MY WISHES

I understand that circumstances beyond my control may cause me to be admitted to a health care institution whose policy is to decline to follow advance directives that conflict with certain religious or other beliefs. If I am a patient in such health care institution when this advance directive comes into effect, I direct that my consent to admission shall not constitute implied consent to procedures or courses of treatment mandated by religious or other policies of the institution, if those procedures or courses of treatment conflict with this advance directive. Furthermore, if the health care institution in which I am a patient declines to follow my wishes as set out in the advance directive, I direct that I be transferred in a timely manner to a hospital, nursing home, private home, hospice or other institution which will agree to honor the instructions set forth in this advance directive.

10. MY WISHES CONCERNING OTHER MATTERS

	Yes	No
a. I consent to medical treatments that are experimental.	____	____
b. I want to donate organs/tissues.	____	____
c. I consent to an autopsy.	____	____
d. I consent to use of all or part of my body for medical education or research.	____	____
e. I have named the following individual(s) listed below as my designated agent(s) for arrangements which agent(s) believes are in accordance with my wishes with regard to the disposition of my remains.	____	____

My designated agent:

Name: _____

Address: _____

_____

Telephone: _____

(day) (evening) (mobile)

My alternate agent:
If my agent is unable or unwilling to serve, or unavailable, or if my agent is a spouse or partner from whom I am separated or divorced when decisions need to be made for me, then I name this alternate agent:

Name: _____

Address: _____

_____

Telephone: _____

(day) (evening) (mobile)

f. Disposition of my remains: My current preference of how I want my remains to be disposed of is as follows, but may be amended by me at any time:

_____ funeral _____ burial _____ cremation _____ memorial _____ interment

Other specific instructions: _____

_____

11. IF A COURT APPOINTMENTS A GUARDIAN FOR ME

If I have named a health care agent, I want my agent to be my guardian. If he/she cannot serve, then I want my alternate agent to be my guardian, if I have named an alternate. If the court decides to appoint someone else, I ask that the court require the guardian to consult with my agent (or alternate) concerning all health care decisions that would require my consent if I were acting for myself.

12. HOW THIS DIRECTIVE CAN BE REVOKED OR CANCELED

This directive can be revoked by a written statement to that effect, or by any other expression of intention to revoke. However, if I express disagreement with a particular decision made for me, that disagreement alone is not a revocation of this document.

13. SUMMARY AND SIGNATURE

I understand what this document means. If I am ever unable to make my own health care decisions, I am directing whoever makes them for me to do as I have said here. This includes withholding and/or withdrawing life-sustaining medical treatment, which might result in my death occurring sooner than if

everything medically possible were done. I make this document to become effective even if I become incompetent or otherwise disabled.

_____ _____
Name Date

14. STATEMENT OF WITNESSES

_____ is personally known to me, and I believe him to be of sound mind and to have completed this document voluntarily. I affirm I am at least 18 (eighteen) years old, not related to him by blood, marriage, or adoption, and not his health care agent named in this document. As far as I know, I am not a beneficiary of his will or any codicil, and I have no claim against his estate. I am not directly involved in his health care, and I am not an employee of his physician or a health care facility where the person making this document resides

.

WITNESS I **WITNESS 2**

_____ _____ _____ _____
Signature Date Signature Date

_____ _____
Printed Name Printed Name

STATE OF WASHINGTON)
) ss.
COUNTY OF CLALLAM)

On this _____ day of _____, 2017, before me, the undersigned, a Notary Public in and for the State of Washington personally appeared _____ (the Principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument; and acknowledged that he executed it as his voluntary act or deed.

I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence, and that I am satisfied as to the genuineness and due execution of this document.

_____
NOTARY PUBLIC in and for the State of Washington residing at _____
My Commission expires: _____