



**WHEN RECORDED RETURN TO:**

Debbie R. Seitz  
PO Box 13  
North Bonneville, WA 98639

Please print or type information **Washington State Recorder's Cover Sheet** (RCW 65.04)

**DOCUMENT TITLE(S)** (or transaction contained therein) (all areas applicable to your document must be filled in)

Directive To Physicians

**REFERENCE NUMBER(S)** of Documents assigned or released:

☐ Additional numbers on page \_\_\_\_ of document.

**GRANTOR(S):**

1. Debbie R. Seitz 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

☐ Additional names on page \_\_\_\_ of document.

**GRANTEE(S):**

1. Durable Power of Attorney 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

☐ Additional names on page \_\_\_\_ of document.

**LEGAL DESCRIPTION** (Abbreviated: i.e. Lot, Block, Plat or Section, Township, Range, Quarter):

☐ Complete legal on page \_\_\_\_ of document.

**Assessor's Property Tax Parcel #**

☐ Additional parcel numbers on page \_\_\_\_ of document.

The Auditor/Recorder will rely on the information provided on this form. The staff will not read the document to verify the accuracy or completeness of the indexing information.

"I am signing below and paying an additional \$50.00 recording fee (as provided in RCW 36.18.010 and referred to as an emergency nonstandard document), because this document does not meet margin and formatting requirements. Furthermore, I hereby understand that the recording process may cover up or otherwise obscure some part of the text of the original document as a result of this request."

\_\_\_\_\_  
Signature of Requesting Party

Note to Submitter: Do NOT sign above nor pay additional \$50 fee if the document meets margin/formatting requirements.

## DIRECTIVE TO PHYSICIANS

I, DEBBIE R. SEITZ, a resident of the County of Skamania, State of Washington, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below and do hereby declare that:

(a) If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians, and the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and my physicians determine that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally. I understand that 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.

(b) 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 and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences from such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney, court action or otherwise, I request that the person be guided by this directive and any other clear expression of my desires.

(c) 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.

(d) If any portion of this directive shall be invalid, void, voidable or unenforceable, such invalidity or enforceability shall have no effect on any other portion hereof.

(e) I understand the full import of this directive and am emotionally and mentally competent to make this directive.

(f) In addition to the foregoing, and recognizing that the law in Washington concerning the matters covered in this paragraph (f) is unclear, it is my desire that my life not be prolonged through the use of "feeding tubes, intubation, hydration, life-sustaining drugs, mechanical ventilation or cardiopulmonary resuscitation" in the event the circumstances described in paragraphs (a) and (b), above, exist; without regard as to whether or not my death is imminent. Also, whether or not my death is imminent or my condition is terminal, if two physicians certify that if I am in an "irreversible coma" I do not wish to receive medical treatment that will only postpone the moment of my death, including but not limited to the types of medical treatment described in this paragraph (f). For this purpose an "irreversible coma" refers to a permanent loss

