WORRY-FREE WEDNESDAYS

END-OF-LIFE PLANNING CHECKLIST

☐ **1. Complete an End-of-Life Values Worksheet**
- Help clarify your perspective and beliefs about living and dying
- Use as a guide for conversations with those who support you to explain your choices

☐ **2. Complete Advance Directives**
- Select, complete and sign a Durable Power of Attorney for Healthcare
- Select, complete and sign a Health Care Directive /Living Will
- Evaluate need for POLST, Dementia Directive and Oral Feeding & Drinking Directive
- Add addendum in writing or video if you choose to share additional end-of-life wishes, or reinforce choices

☐ **3. Identify Supportive Primary Care Physician and Care Providers**
- Talk to your physician and care providers about options you would want to consider i.e.. Natural Death, Medical Aid in Dying, Voluntarily Stopping Eating and Drinking, and Stopping Treatment. Make sure they can and will support these choices.

☐ **4. Provide Copies of Advance Directives to Key People and Display POLST**
- Share end-of-life planning documents with loved ones, health care agent, other support team members, and ask all medical providers to add a copy to your electronic files
- Display a copy of POLST form prominently if you have one

☐ **5. Evaluate need for Last Will & Testament and Management of Financial Records, Digital Accounts, and Insurance Documents**
- Ensure updated financial and legal documents and all digital account usernames and passwords are accessible by those you've selected to manage your affairs
- Name Durable Power of Attorney for Finances if needed

☐ **6. Prepare Final Disposition Arrangements and Designated Agent**
- Decide what you want to happen to your body when you die and who will be responsible
- Complete designated agent form, disposition authorization form and vital statistics form

☐ **7. Shape Your Legacy**
- Document and share any wishes you have for a gathering after you die – Memorial, Funeral Service, Celebration of Life, etc.
- Consider letters, gifts, sentiments you want to leave for those left behind

www.worryfreewednesdays.com
info@worryfreewednesdays.com

WORRY-FREE WEDNESDAYS

Values Worksheet: How important are the following?

Low High

	1	2	3	4	5
Staying true to my values, spiritual beliefs and traditions.					
Having autonomy and making choices about my care.					
Preserving quality of life.					
Living as long as possible, regardless of quality of life.					
Letting nature take its course.					
Dying in a short while rather than prolonging life if I'm ill.					
Being conscious, even if uncomfortable and experiencing pain.					
Being slightly sedated, to avoid pain.					
Being independent.					
Aging in place.					
Being free of physical limitations or disabilities.					
Being mentally alert and competent.					
Leaving good memories for my family and friends.					
Contributing to medical research or teaching.					
Avoiding expensive care that doesn't extend quality of life.					
Leaving money to family, friends, and/or charity.					

Durable Power of Attorney for Health Care
for

_____

[My Name]

1. **Agent.** I choose _____as my Agent with full authority to manage my health care.

2. **Alternate.** If _____is unable or unwilling to act, I choose _____as my Agent with full authority to manage my health care.

3. **My Rights.** I keep the right to make health care decisions for myself as long as I am capable.

4. **Durable.** My Agent can still use this power of attorney document to manage my affairs even if I become sick or injured and cannot make decisions for myself. This power of attorney shall not be affected by my disability.

5. **Start Date.** This power of attorney document is effective on the day I sign it.

6. **End Date.** This power of attorney document will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney document will end if either of us files for divorce in court.

7. **Revocation.** I revoke any other power of attorney for health care documents I have signed in the past. I understand that I may revoke this power of attorney document at any time by giving written notice of revocation to my Agent.

8. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including the power to make health care decisions and give informed consent to my health care, refuse and withdraw consent to my health care, employ and discharge my health care providers, apply for and consent to my admission to a medical, nursing, residential or other similar facility that is not a mental health treatment facility, serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and to visit me at any hospital or other medical facility where I reside or receive treatment.

9. **Government Benefits**. My Agent shall have full power and authority to arrange for and manage all government benefits on my behalf, including but not limited to signing and consenting to applications, contracts, ongoing eligibility review agreements, and care plans for federal and state cash, food, medical, housing, and long-term care benefits and services.

10. **Mental Health Treatment.** My Agent is not authorized to arrange for my commitment to or placement in a mental health treatment facility. My Agent is not authorized to consent to electroconvulsive therapy, psychosurgery, or other psychiatric or mental health procedures that restrict physical freedom of movement.

11. Accounting. My Agent shall keep accurate records of my financial affairs and show these records to me at my request.

12. Nomination of Guardian or Conservator. I nominate my Agent as the guardian of my person for consideration by the court if guardianship and/or conservatorship proceedings become necessary.

13. HIPAA Release. I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my Agent.

_____ ▶ _____

Date My Signature (*in front of a notary or witnesses*)

Notarization

State of Washington
County of _____

Signed or attested before me on (*date*) _____
by (*name*) _____.

▶ _____
Signature of Notary

Notary Public for the State of Washington.

My commission expires _____.

Statement of Witnesses (alternative if you can't find a notary)

On the date written above, the declarer signed this Durable Power of Attorney for Health Care in my presence. I believe the declarer is able to make health care decisions, to understand this document, and to have signed it voluntarily.

- I am not related to the declarer by blood, marriage, or state registered domestic partnership.
- I am not a home care provider for the declarer.
- I do not provide care at an adult family home or long-term care facility where the declarer lives.

Witness 1	Witness 2
▶ _____	▶ _____
Signature	Signature
_____	_____
Print Name	Print Name
_____	_____
Address	Address

Health Care Directive

of

_____

[My Name]

I am of sound mind and body, and voluntarily execute this health care directive. If I cannot make decisions for myself, my relatives, friends, agents, and medical providers should fully honor every part of this directive. If any part of this directive is invalid, the rest should be honored. I revoke any health care directives I have signed in the past.

1. **Health Care Values:** The following wishes and preferences should guide all decisions made about my care:

    a. **What makes my life worth living.**

    ☐ Some terminal or serious conditions may stop me from **ever** doing the things that make life worth living for me. In that situation, I want you to stop all treatment except comfort care, pain relief and palliative care if I **cannot ever again**:

    ☐ Recognize my close friends and family in any meaningful way

    ☐ exercise,

    ☐ be outdoors,

    ☐ read,

    ☐ watch tv shows/movies

    ☐ do the following: _____

    ☐ Other: _____

    _____

    _____

    ☐ Life is always worth living. Do everything you can to keep me alive.

    b. **My hopes**. In my last days, I hope to spend my time:

    ☐ With my close friends and family: _____

    _____

☐ With the following comfort items and/or pets:

_____

☐ Eating/drinking the following items, if possible: _____

_____

☐ Listening to the following music: _____

_____

☐ Other: _____

_____

c. **Pain Management.** In my last days, I hope to balance pain management and mental clarity in this way:

☐ I hope to spend my time in as little pain as possible, even if I'm not mentally clear.

☐ Please balance my ability to communicate and remain present with my family against the amount of pain in providing relief.I can tolerate some amount of pain (circle on the scale below) in exchange for more mental clarity.

- ◯ Hardly notice pain
- ◯ Notice pain does not interfere with activities
- ◯ Sometimes distracts me
- ◯ Distracts me, can do usual activities
- ◯ Interrupts some activities
- ◯ Hard to ignore, avoid usual activities
- ◯ Focus of attention, prevents doing daily activities
- ◯ Awful, hard to do anything
- ◯ Can't bear the pain, unable to do anything
- ◯ = As bad as it could be, nothing else matters

d. **My fears.** There are situations or treatments I are concerned about and want to prevent or avoid if possible.

☐ I have a fear of (*examples:* shortness of breath, thirst, choking sensation, nausea, headaches) _____. Please do everything possible to relieve me of that feeling through comfort care.

☐ I don't want to spend our life savings on my final illness. Please provide the least costly comfort care for my end-of-life care.

☐ Other: _____

_____

e. **Where I want to be**. I would like to receive care in the following place/s if possible:

☐ My home.

☐ Hospice care.

☐ An assisted living facility.

☐ An adult family home.

☐ A nursing home.

☐ A hospital.

☐ I know that it may not be possible for me to receive care where I want, given my needs and circumstances at the time. I trust my healthcare decision-maker/s and know that they will make the best decisions for me after considering my values, and consulting with my loved ones and care providers.

☐ Other: _____

_____

f. **Other things to know about me**:

☐ I would like my friends and family to be notified of my condition and given an opportunity to visit me to say goodbye.

☐ I would like to be kept alive for a short period of time if needed to allow friends and family time to travel and say goodbye.

☐ If possible, I would like to be able to look out a window or see nature during my last days.

☐ My religious or cultural traditions require the following practices around health care and end of life care:

_____

_____

☐ Other:

_____

_____

_____

_____

_____

_____

_____

2. **Terminal Illness or Permanent Unconscious Condition.** If my attending physician diagnoses me with a terminal condition or two physicians determine that I am in a permanent unconscious condition, and if my physician/s determine that life-sustaining treatment would only artificially prolong the process of dying, I want:
    a. **Comfort Care and Pain Medication.** If I appear to be experiencing pain or discomfort, I want treatment and medications to make me comfortable, even if my medical providers believe it might unintentionally hasten my death.
    b. **Withdraw Artificial Life Support.**
    The following treatment should be **withheld** or **withdrawn** from me:

    - ☐ Artificial nutrition
    - ☐ Artificial hydration
    - ☐ Artificial respiration (ventilator)
    - ☐ Cardiopulmonary Resuscitation (CPR), including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure
    - ☐ Surgery to prolong my life or keep me alive
    - ☐ Blood dialysis or filtration for lost kidney function
    - ☐ Blood transfusion to replace lost or contaminated blood
    - ☐ Medication used to prolong life, not for controlling pain
    - ☐ Any other medical treatment used to prolong my life or keep me alive artificially

3. **Health Care Institutions.** If I am admitted to a hospital or other medical institution that will not honor this directive due to religious or other beliefs: (1) my consent to admission is not implied consent to treatment, and (2) I want to be transferred as soon as possible to a hospital or other medical institution that will honor my directive.

4. **Changes and Cancellation.** I understand that I can change the wording of this directive before I sign it. I also understand that I can cancel this directive at any time.

_____ ▶ _____

Date My Signature (*in front of notary or witnesses*)

Notarization (preferred)

State of Washington

County of _____

I certify that I know or have satisfactory evidence that _____, is the person who appeared before me, signed the Health Care Directive above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

_____

Date

▶ _____

Signature of Notary

Notary Public for the State of Washington.

My commission expires _____.

Statement of Witnesses (only if you cannot find a notary)

On (date) _____, the declarer of this document signed it in my presence. I believe the declarer is able to make health care decisions, to understand this document, and to have signed it voluntarily.

- I am not related by blood or marriage to the declarer.
- I am not now entitled to receive any portion of the declarer's estate, either by will or by operation of law, or as a result of any claim against the declarer.
- I am not the declarer's attending physician or an employee of that physician or of a health facility in which the declarer is a patient.

Witness 1	Witness 2
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	_____
Address	Address
_____	_____

My Name: _____ My Date of Birth: _____

Health Care Directive Contact Information
(Attach this to your Directive)

My name – first, middle, last	
My date of birth	My primary care medical provider
My phone number	My email address
My mailing address	

☐ I have a **Durable Power of Attorney** form that lets someone else (my "agent") make health care decisions for me if I am not able.

My health care agent's name

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: *See page 2 for complete instructions.*

MEDICAL CONDITIONS / INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A

CHECK ONE

Use of Cardiopulmonary Resuscitation (CPR): **When the individual has NO pulse and is not breathing.**

☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*

☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B

CHECK ONE

Level of Medical Interventions: **When the individual has a pulse and/or is breathing.**

Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort.
Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): _____

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with: ☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**		DATE **(mandatory)**
	PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**		PHONE
X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**			PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association
Physician Driven, Patient Focused

Washington State Department of Health

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST**.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL	DATE OF BIRTH / /

Additional Contact Information (if any)

LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)

☐ **Check here if not discussed**

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.
Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

☐ Preference is to avoid medically assisted nutrition.
☐ Preference is to discuss medically assisted nutrition options, as indicated.*
Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.

Discussed with: ____ Individual ____ Health Care Professional ____ Legal Medical Decision Maker

Directions for Health Care Professionals

NOTE: An individual with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Any incomplete section of POLST implies full treatment for that section. This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

Completing POLST

- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.
- POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at www.wsma.org/POLST.

NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.

Honoring POLST

Everyone shall be treated with dignity and respect.

SECTIONS A AND B:

- No defibrillator should be used on an individual who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
- Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate "Selective" or "Full Treatment."

Reviewing POLST

This POLST should be reviewed whenever:

- The individual is transferred from one care setting or care level to another.
- There is a substantial change in the individual's health status.
- The individual's treatment preferences change.

To void this form, draw a line across the page and write "VOID" in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.

Review of this POLST form: <u>Use this section to update and confirm order and preferences.</u>

This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			☐ No Change ☐ Form Voided ☐ New Form Completed

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST, visit **www.wsma.org/POLST**.

TO BE PRESENTED TO FUNERAL HOME/REDUCTION FACILITY AT TIME OF DEATH

Designated Agent for Disposition
Washington State

I, _____designate the following agent(s) to act on my behalf for the sole purpose of directing my disposition arrangements.

Primary Agent's Full Name: _____

Primary Agent's Address: _____

Primary Agent's Phone(s): _____ Relationship: _____

If my Primary Agent is for any reason unable or unwilling to serve in this capacity or does not make contact with the disposition entity I've named within 5 business days of my death, I then name the following person.

Alternate Agent's Full Name: _____

Alternate Agent's Address: _____

Alternate Agent's Phone(s): _____ Relationship: _____

I direct that all of my family and survivors shall honor this authorization. I direct that any funeral home, cemetery, cremation authority, memorial society or designated agent shall be held harmless for arranging or handling the disposition of my remains, if done in reliance upon this authorization. If I have not executed a written disposition request or authorization, nor filed or prepaid my arrangements with a licensed funeral establishment or cemetery authority, then I authorize the designated agent(s) listed here to select appropriate disposition arrangements for me including the type, place and method. Neither my designated agent(s) nor my surviving relatives can alter any prearrangements I have made. **If I have not provided sufficient funds to cover my prearrangements, I direct my designated agent(s) to pay the remainder of the cost and my estate to promptly reimburse my designated agent(s) for any personal funds advanced to pay for my disposition arrangements.** My designated agent(s) have complete authority to act on my behalf and direct any and all details related to my disposition arrangements that I have not already prearranged or authorized, including but not limited to obituary, funeral or memorial service, cemetery, monument, memorialization, reception or other related matters.

Declarant's Signature: _____ Date: _____
(Only the Declarant may sign, not the POA or Spouse)

Printed Name of Declarant: _____Date of Birth: _____

UNDER WASHINGTON LAW, TO BE VALID, THIS FORM MUST BE SIGNED IN THE PRESENCE OF A WITNESS:

Witness Signature: _____Date: _____

Printed Name of Witness: _____ Phone:_____

Address of Witness: _____

KEEP WITH IMPORTANT END-OF-LIFE PLANNING DOCUMENTS

Directions for the Disposition of my Body
Washington State

I, _____ hereby declare that it is my desire upon my death for my remains to be handled in the following manner: *(Initial your choice below)*

_____ BURIAL	**_____ ALKALINE HYDROLYSIS (Aquamation)**	**_____ CREMATION**
_____ GREEN BURIAL	**_____ NATURAL ORGANIC REDUCTION**	**_____ FULL BODY DONATION**

I may further direct the following funeral home, reduction facility or organization to manage my disposition.

_____ _____
(Name of funeral home, reduction facility or organization) (Phone number)

_____
(Address)

☐ **I HAVE** filled out the necessary disposition authorization forms and they are on file with the named entity above.
☐ **I HAVE** filled out the necessary organ donation or full body donation forms.
☐ **I HAVE** prearrangements where I have purchased a final expense whole life insurance policy with the named entity above.
☐ **I HAVE** prearrangements where I have placed funds into a master trust managed by the named entity above.
☐ **I HAVE** purchased (check all those purchased) ____cemetery property____headstone____opening/closing fee _____burial vault/liner with _____.
☐ **I HAVE NOT** purchased any of the above and need my designated disposition agent to do that on my behalf and be reimbursed from my estate where possible.

I may further direct that the funeral home or reduction facility release my remains in the following manner:

☐ **Release my remains to the following person(s):**

Name: _____ **Name:** _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

City/State/Zip:_____ City/State/Zip:_____

Phone: _____ Phone: _____

☐ **Deliver or ship my remains to:**

Name: _____ Relationship: _____

Address: _____

City/State/Zip:_____ Phone: _____

I may further direct that my remains be buried at the following:

☐ **Cemetery/ Established Family Burial Ground**

Name of Place of Interment: _____

City/County & State: _____

Phone:_____

☐ **Mausoleum**

Name of Place of Interment: _____

City/County & State: _____

Phone:_____

I may further direct that my remains be scattered/spread in the following location:

Name/Address of Location: _____

Name/Address of Location: _____

Name/Address of Location: _____

Other: _____

Declarant's Signature: _____ **Date:** _____

Printed Name of Declarant: _____ Date of Birth: _____

Organ, Tissue and Full Body Donation
Washington State

I, _____ hereby declare that it is my desire upon my death for the following organ, tissue or full body donations to be made if determined to be eligible at time of death. If not eligible, please refer to disposition directions.

Eye/Cornia Donation

I ☐ do ☐ do not wish to donate my eyes at the time of my death to the eye bank.

☐ **I have chosen an organization** to work with on my donation like Sightlife, Donate Life Northwest, Eye Bank Association of America, etc.

_____

(Name of Organization) (City) (State) (Zip)

Organ/Bone/Tissue Donation

I ☐ do ☐ do not wish to donate such other organs, bone or tissue, at the time of death as may be considered medically useful. This also authorizes donation of pacemaker, if applicable.

☐ **I have chosen** an organization to work like LifeCenter Northwest, etc.

_____

(Name of Organization) (City) (State) (Zip)

Full Body Donation

I ☐do ☐do not wish to donate my full body to the University of Washington, Washington State University or other university willed body program for teaching or research purposes.

I have registered with the following program:

☐ **UW Willed Body Program** at (206) 543-1860 or wbp.biostr.washington.edu.

☐ **Washington State University Body Donation Program** at (509) 335-2602 or medicine.wsu.edu/give/willed-body-program.

☐ **Other:**_____

(Name of Organization) (City) (State) (Zip)

Declarant's Signature: _____ **Date:** _____

Printed Name of Declarant: _____Date of Birth: _____

Vital Statistics Form
Information Required for Death Certificate

Personal Information:

Full Legal Name: _____
(First) (Middle) (Last)

Other Names/(AKAs): _____
(First) (Middle) (Last)

Date of Birth: _____
(Month) (Date) (Year)

Birthplace: _____
(City) (County) (State or Country)

Marital Status: ☐ Single ☐ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Registered Domestic Partner

Name of spouse or domestic partner: _____
(First) (Middle) (Last – *must use maiden name*)

Father's Name: _____
(First) (Middle) (Last)

Mother's Maiden Name: _____
(Before first marriage) (First) (Middle) (Last)

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary **Served in the US Armed Forces?** ☐ Yes ☐ No

Social Security Number _____-_____-_____ **Race(s) List all that apply:** _____

Hispanic Ethnicity: ☐ No ☐ Yes ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Cuban ☐ Other: _____

Residence:

_____
(Street Address, Apt. #) (City) (State) (Zip)

Resided at this address since: _____ **Residence Inside City Limits?** ☐Yes ☐ No ☐ Unknown
(Year)

Tribal Reservation Name:_____
(Name of Reservation)

Education/Occupation:

Education completed (highest degree earned): ☐ 8th Grade or Less ☐ 9 th-12th grade: no diploma ☐ High School Graduate or GED completed ☐ Some college credit, no degree ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate ☐ Unknown

Occupation (Kind of Work Done. Do not use "retired", give former occupation(s): _____
Industry (Do not use company name(s), i.e. "Education"): _____

My Wishes to Honor My Life
Instructions to Surviving Relatives and Designated Agents

I, _____ declare my wishes to have my life honored in the following manner after I die. I will look to my surviving relatives and/or designated agents to follow these directions where possible and only to make changes if and when my wishes can not be honored.

Declarant's Signature: _____ Date: _____

Type of gathering (Funeral, Memorial, Graveside Service, Celebration of Life, Wake, etc. Be as specific as possible):

_____

_____.

Location of gathering (Place of Worship, Home, Specific Location in Community, etc. Be as specific as possible):

_____

_____.

People I would like to speak/communicate at my gathering:

_____.

Gifts, gestures, mementos I would like given away to those who attend:

_____

_____.

Specific food, flowers, music, photos, or other items/wishes I would like represented:

_____

_____.

Notices: I ☐ do ☐ do not want notices of my death published.

Memorial Gifts: I ☐ do ☐ do not prefer memorial gifts or donations in lieu of flowers. If memorials requested, I ask that donations be sent to the following organization(s):

_____.

☐ A gathering to honor my life and all other decisions are up to surviving relatives and loved ones to decide.

Thoughts for My Obituary/Eulogy
Instructions of What to Include/What I Want Written About Me

The name in which I'd like to be referred to _____

Date and place of birth_____.

Parent names _____ _____
(Mother, Maiden Name) (Father)

Locations where I grew up and lived and when _____

_____

_____.

Education/military history (schools I went to and when I attended, graduated, degrees)_____

_____

_____.

Personal life highlights/mentions_____

_____

_____

_____.

Hobbies, interests, groups highlights/mentions _____

_____

_____

_____

_____.

Profession and career highlights/mentions_____

_____

_____

_____

_____.

Survivors I would like mentioned and relationship to me:

_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)

Predeceased by:

_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)
_____ (name)	_____ (Relationship)	_____ (name)	_____ (Relationship)

Other thoughts/mentions I would like included in my obituary and/or eulogy:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you would like to <u>write your own obituary or eulogy</u>, simply staple or attach a document to this form.