SUPPLEMENT TO ADVANCE HEALTH CARE DIRECTIVE DUE TO COVID-19

SUPPLEMENT TO DIRECTIVE made this _____ day of _____, 20_____.

I, _____ **[name]**, of _____ **[address]**, having the capacity to make health care decisions, willfully, and voluntarily make known my desire that his document is a supplement to the Advance Health Care Directive that I signed on _____ (my "AHCD"). The purpose of this supplemental document is to express my specific wishes in the event that I am diagnosed with COVID-19 or exhibit symptoms of COVID-19 that suggest testing for the virus is appropriate. I intend for this supplement document to be treated as an Advance Health Care Directive under RCW 70.122.030.

NOTWITHSTANDING any directions, instructions, wishes, choices, or intentions expressed to the contrary in my AHCD, the following statements that are initialed below shall be incorporated into my AHCD and followed by my family members and physicians:

(initial all those that apply)

1. _____ If I exhibit any symptoms that suggest I may be afflicted with COVID-19, I wish to be tested for such virus and consent to any means of testing that are available.

2. _____ If I am diagnosed with COVID-19, I consent to being quarantined in a hospital; however I prefer to be quarantined in my own home if at all possible.

3. _____ I consent to my ☐ agent, ☐ spouse, ☐ children, ☐ parents, ☐ others: _____ **[check one or more]** to visit me in any way possible and communicate with me by whatever means possible during any period of quarantine due to COVID-19. I wish to remain in contact with the above-described individuals to the extent possible.

4. _____ If intubation, artificial ventilation, or any other medical aids or devices may provide assistance to me while diagnosed with COVID-19, I expressly wish and consent to the administration of those aids. Any "end of life" decisions that I have previously made indicating a wish to withhold life-sustaining measures do not apply while I am afflicted or diagnosed with COVID-19. I intend to be kept alive by all means possible if I am afflicted or diagnosed with COVID-19.

5. _____ I expressly consent to any medication that may help me recover from COVID-19, including any medication that is considered experimental. I give my agent authority to sign all documentation, including waivers, indemnification agreements, and "hold harmless" agreements, that may be required for me to receive such medication.

6. _____ I consent to participate in any trials being conducted for treatment of COVID-19 and give my agent the authority to sign any documentation regarding such trial.

7. _____ I expressly authorize my Agent to communicate decisions to any medical provider verbally, in person, by telephone, via email, via web conference including but not limited to such services as Skype, FaceTime, Zoom, or in any other manner appropriate to the circumstances. Further, I expressly hold harmless any medical provider for relying on such communications of decisions and directions by my Agent. The express purpose of this provision is to foster decision making by my Agent in remote or indirect manners that may be necessary or advisable given whatever circumstances accompany such decision making.

8. _____ If there is any conflict between a provision in my AHCD and a provision in this supplemental document, the provision in this supplemental document will apply.

9. _____ I give my agent the authority to consent on my behalf to any additional precautionary measures, treatments, communications, provisions, routines, arrangements, or other matters that may be beneficial to me due to COVID-19. I intend for the preceding sentence to be interpreted as broadly as possible, knowing that all matters regarding COVID-19 are rapidly changing and developing any likely will further change after I sign this supplemental document.

10. _____ If I am unable to comply with state law regarding the execution of Advance Health Care Directives due to shelter-in-place mandates or because I am in quarantine or my concern for my health and safety precludes compliance with such formalities, I ask my health care providers and any court of competent jurisdiction to give this document the same force and effect as if it had been signed in compliance with state law.

Declarant:

_____

[signature]

_____, the declarant, voluntarily signed this Supplement to Directive to Physicians in my presence. The declarant is personally known to me and I believe her to be capable of making health care decisions. I am not related by blood or marriage to the declarant, nor entitled by law, will or otherwise to receive part of the declarant's estate. I am not the declarant's attending physician or an employee of that physician or of a health facility in which the declarant is a patient.

_____

[signature – please print name under this line]

_____

[street address]

_____

[city, state]

_____

[signature – please print name under this line]

_____

[street address]

_____

[city, state]