MY DECISION TO VOLUNTARILY STOP EATING AND DRINKING

I am making this document because I want my medical and long-term care providers, caregivers, family, and other loved ones to respect, honor, support, and uphold my decision to voluntarily stop eating and drinking (VSED).

I am a person with capacity and have considered all the options that are available to me. I value life very much, but I believe that to continue living in certain circumstances is worse than death. I understand that stopping eating and drinking will result in my death.

I want my family and caregivers to refrain from eating in my presence and to try to prevent or limit any cooking odors or the smell of food from reaching and affecting me.

I do not want to be tempted, persuaded, cajoled, harassed, or coerced to eat or drink.

I do not want to be offered food or water; if I want them, I will ask for them.

I want my caregivers to focus on comfort care and pain and symptom management, and I want to be allowed to die as peacefully as possible.

If the long-term care facility where I already reside will not honor my decision to VSED or attempts to undermine it, I want to be transferred to one that will or to the home of a family member or friend who supports my decision.

If I become unable to make decisions for myself as a result of a coma, being heavily medicated, or for any other reason, I want my wishes for life-sustaining treatment, including medically assisted artificial nutrition and hydration (for example, tube feeding, nasogastric tube, total parenteral nutrition) to be honored as documented in my health-care directive or my Physician Orders for Life-Sustaining Treatment (POLST) form.

If I did not make a health-care directive or POLST form or they cannot be located, I want my health care agent's or other legal surrogate decision maker's decisions about life-sustaining treatment to be honored, including those addressing medically assisted artificial nutrition and hydration.

I do not want others to substitute their choices for mine because they disagree with my decision to VSED or 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 started the VSED process, or if I had known certain medical facts that developed later, I would change my mind.

_____ _____ _____
Signature Printed Name Date

Statement of Witnesses

The afore-named person is personally known to me, and I believe him/her to be of sound mind and to have completed this document voluntarily. I affirm I am at least 18 years old, not related to by blood, marriage, or adoption, and not the health care agent named in an Advance Directive for Health Care. As far as I know, I am not a beneficiary of his/her will or any codicil, and I have no claim against the estate. I am not directly involved in his/her health care, and I am not an employee of the physician or a health care facility where the person making this document may reside.

WITNESS 1

_____ _____
Signature Date

_____ _____
Printed Name Phone

_____
Address

WITNESS 2

_____ _____
Signature Date

_____ _____
Printed Name Phone

_____
Address

NOTARIZATION {optional}

STATE OF WASHINGTON County of _____

I certify that I know or have satisfactory evidence that _____ signed this document and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in this document.

Dated this_____day of_____, 20_____

_____
NOTARY PUBLIC in and for the State of Washington

Residing at _____

My commission expires _____