VIRGINIA ADVANCE MEDICAL DIRECTIVE

This form with slight variations, is the form approved by the Virginia General Assembly in the Health Care Decisions Act. The form contains both a "Living Will" portion, a portion in which you may appoint an agent to make health care decisions for you, and a portion in which you may appoint an agent to make an anatomical gift. You may complete any one or all of these portions of the form. Virginia law does not require the use of this particular form in order to make a valid advance directive. If you have legal questions about this form, or would like to develop a different form to meet your particular needs, you should talk with an attorney. You must sign your advance medical directive in the presence of two witnesses who are not blood relatives or your spouse. It is your responsibility under Virginia law to provide a copy of your advance directive to your attending physician. You also should provide copies of the directive to close relatives and/or friends.

ADVANCE MEDICAL DIRECTIVE made this ___ day of _____, _____

I, _____, willfully and voluntarily make known my desire and o hereby declare:
(Cross through this portion if you do not want to make a living will in this form.)

"Living Will" Portion of Advance Medical Directive

If at any time my attending physician should determine that I have a terminal condition where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. (OPTION: I specifically direct that the following procedures or treatments be provided to me: _____

_____

_____

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

(Cross through this portion if you do not want to appoint an agent to make health care decisions for you.)

Appointment of Agent to Make Health Care Decisions

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document:

_____

Primary Agent Telephone Number

_____

Address

If the above named primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as successor agent to serve in that capacity:

_____

Successor Agent Telephone Number

_____

Address

I hereby grant to my agent, named above, full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment. The phrase "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed medical decision or unable to make a rational evaluation of the risks and benefits of a proposed medical decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way. My agent's authority hereunder is effective as long as I am incapable of making an informed decision.

The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. Such certification shall be required before treatment is withheld or withdrawn, and before, or as soon as reasonably practicable after, treatment is provided, and every 180 days thereafter while the treatment continues.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with treatment or nontreatment. My agent shall not authorize a course of treatment which he knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what treatment choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he believes to be in my best interests.

Further, my agent shall not be liable for the costs of treatment pursuant to his/her authorization, based solely on that authorization.

OPTION: Powers of my agent. (Cross through any language you do not want and add any language you do want.)

The powers of my agent shall include the following:

A. To consent to or refuse or withdraw consent to any type of medical care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including but not limited to artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of recommended

dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastens my death;
B. To request, receive, and review any information, verbal or written, regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information;
C. To employ and discharge my health care providers;
D. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, adult home or other medical care facility for services other than those for treatment of mental illness requiring admission procedures provided in Article 1 (§37.1-63 et seq.) of Chapter 2 of Title 37.1;
E. To make decisions about who may visit me, subject to physician orders and policies of any institution to which I am admitted.
F. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

(Cross through this portion if you do not want to appoint an agent to make an anatomical gift or organ, tissue or eye donation for you.)

Appointment of Agent to Make Anatomical Gift

Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donation may be made pursuant to applicable Virginia law governing anatomical gifts (§32.1-289 et seq.) and in accordance with my directions, if any. I hereby appoint,

_____

as my agent, of _____

Address

_____

Phone number

to make any such anatomical gift or organ, tissue or eye donation following my death.

I further direct that: _____

(Declarant's directions, if any, concerning anatomical gift or organ, tissue or eye donation)

This advance directive shall not terminate in the event of my disability. By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

_____ _____

Date Signature of Declarant

The declarant signed the foregoing advance directive in my presence. I am not the spouse or a blood relative of the declarant.

_____

Witness

_____

Witness