ADVANCE MEDICAL DIRECTIVES

This form contains a "Living Will" portion, a "Durable Power of Attorney for Health Care" portion and a portion in which you may appoint an agent to make an anatomical gift. You may complete any one or all portions of this form. The form must be signed on the reverse side in the presence of two witnesses who are not blood relatives or your spouse. Please cross out any section not used. Copies should be given to your attending physician, relatives and agents.

LIVING WILL made this _____ day of _____ 20_____. I _____ willfully and voluntarily make known my desires and do hereby declare:

If at any time my attending physician should determine that I have a terminal condition or when medical treatment is futile; where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that life-prolonging procedures, (CPR, Intubation/Ventilation, Artificial Nutrition, Artificial Hydration) be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me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 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. This advance directive shall not terminate in the event of my disability. By signing below, I indicate that I understand the purpose and effect of this document.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE made this _____ day of _____ 20_____.
I _____hereby appoint the following as my agent(s) to make health care decisions on my behalf as authorized in this document.
Primary agent: name, address and phone number _____

_____

Secondary agent: name, address and phone number
_____

_____

I hereby grant my agent/agents, named above full power and authority to make health care decisions on my behalf as directed whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment.

Appointment of Agent to Make Anatomical Gift

Upon my death, I direct that an anatomical gift of all or any part of my body 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 following my death.
I further direct that:

_____
(Declarant's directions, if any, concerning anatomical gift)

Signed: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ***Date:*** _ _ _ _ _ _ _ _ _ _

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

Witnesses: (1) _____

(2) _____

Date: _____

This authorization conforms with Virginia Law and is effective until revoked by the person making this decision. It should be made available to the attending physician and any health care facility to which the patient may be transferred. Photostatic copy considered as original.