# 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 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 _____ (Month), _____ (Year).

I, _____, willfully and voluntarily make known my desire and do hereby declare:

(Cross through this box 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procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me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 box 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