

## DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, “the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a ‘scientific’ process.” Because of “political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective” (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that “The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow,” and suggesting that revised and enhanced documents “may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes” (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

*Lifecare Directives* staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic professionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or “health care instruction” or “declaration”) and medical power of attorney (or “proxy”) forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, “*Should I Use a Shorter Standard Directive?*” available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

**Lifecare Directives, LLC**  
5348 Vegas Drive  
Las Vegas, NV 89108  
[www.lifecaredirectives.com](http://www.lifecaredirectives.com)  
Toll Free: (877) 559-0527

~ Lifecare Directives ~



*Statutory  
Advance Directive  
For  
Virginia Residents*



*Standard State Statutory  
Advance Directive for  
Health Care Choices*



~ Lifecare Directives ~

*Statutory  
Advance Directive  
For  
Virginia Residents*



*Standard State Statutory  
Advance Directive for  
Health Care Choices*

***Important Notice:***

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warranted to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

# Statutory Advance Directive For Virginia Residents

---

Print Full Name

Date of Birth

---

**Your right** (when age 18 or older): To Document Your Personal Wishes,  
and to have these wishes followed ~~

The Virginia state legislature has designed a combined Power of Attorney for Health Care and Living Will (the “Advance Medical Directive”) for use by the public. As this document was designed by your state government, it is in full compliance with all applicable statutes and laws.

There is an introduction that summarizes the scope and purpose of the document, as well as providing directions for its completion. Read it carefully to ensure that your Advance Directive is fully and properly filled out.

*By completing your directive, you can have the peace of mind that some of your wishes are known and can be followed. It is also a meaningful gift to those you love. Your completed directive will help ensure that you r loved ones will have to make fewer difficult choices for you without having an understanding of what you would want done.*

---

## **Understanding Your Directive:**

To make the *best* choices for your medical care, your physician needs to know your wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to speak due to severe illness or injury, this may not be possible. Completing an Advance Medical Directive will help your family and physicians know who should speak for you, and what you want, if you cannot speak for yourself.

You can **revoke** (cancel) this directive at **any** time by: **1)** writing “revoked” across the front of the directive, followed by your signature and date, and the signature of at least one witness age 18 years or older ; **2)** by completing a Notice of Revocation; or **3)** by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4)** by *simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *only at the time of first completion*. Any scope-of-authority changes needed *after* your directive has been witnessed must be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing “deleted” beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin

immediately beside the change. If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions you have described.

Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

---

***Instructions for Completing the Directive:***

To complete the document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write “No,” “None,” or “Does Not Apply” in areas that would otherwise be left blank.

*If there is anything in this document that you do not understand, you should ask your physician, another health care professional, or an attorney for help.*

## **ADVANCE MEDICAL DIRECTIVE**

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

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: *(initial only one)*

\_\_\_\_\_ 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.

***OR:***

\_\_\_\_\_ (***OPTIONAL***) 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 advance directive shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal.

(OPTIONAL)  
**APPOINTMENT OF AGENT**  
(Cross Through If You Do Not Want to Appoint an Agent  
to Make Health Care Decisions for You.)

I do hereby appoint:

**Name of Agent:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

~ as my agent to make health care decisions on my behalf as authorized in this document.

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

**Name of Alternate:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

I hereby grant to my agent(s), as 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 non-treatment. 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.

(OPTIONAL)  
**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; and
- E. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

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

(OPTIONAL)  
**APPOINTMENT OF AN AGENT TO MAKE AN ANATOMICAL GIFT  
OR ORGAN, TISSUE, OR EYE DONATION**

*(Cross Through If You Do Not Want to Appoint an Agent to Make an  
Anatomical Gift or Any Organ, Tissue or Eye Donation for You)*

Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations may be made pursuant to Article 2 (§32.1-289 et seq.) of Chapter 8 of Title 32.1, and in accordance with my directions, if any. I do hereby appoint:

*(initial and/or complete only one)*

\_\_\_\_\_ My health care agent(s) as previously named;

**OR,**

\_\_\_\_\_ Name: \_\_\_\_\_

\_\_\_\_\_ Address: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell Phone or Pager: \_\_\_\_\_ E-mail: \_\_\_\_\_

~ as my agent to make any such anatomical gift or organ, tissue or eye donation following my death. I further direct the following concerning such donation (*any wishes, exclusions, limitations, or other directions*): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE OF PRINCIPAL**

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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

At: (City) \_\_\_\_\_ (State) \_\_\_\_\_

***Required Witnesses***

The declarant signed the foregoing advance directive in my presence.

1<sup>st</sup> Witness: \_\_\_\_\_

Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

2<sup>nd</sup> Witness: \_\_\_\_\_

Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_