Legal Forms & Services

FirstName LastName

VIRGINIA
HEALTH CARE DIRECTIVE

DISCLAIMER:
You use FindLaw's self-help services, forms, and information under your own direction and at your own risk. FindLaw and its affiliates are not a law firm or a substitute for an attorney or law firm and do not represent you or provide legal advice on any matter. The use of FindLaw's self-help services does not create any attorney-client relationship. Communication between you and FindLaw is not protected by attorney-client privilege or as a work product. If you need legal advice or representation, please seek the assistance of an experienced attorney.

The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive in Virginia
After printing your document, you will need to finalize it. Below are the steps:

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive. Review your state's laws on witness requirements for health care directives.

LIVING WILL

FOR

FirstName LastName

This document includes the following:

> Appointment of a health care agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.
>
> Health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

APPOINTMENT OF AGENT

I, FirstName LastName, hereby appoint:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Virginia 11111

Phone: 1111111111

Email: emailaddress@email.com

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

If my primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint:

Name: FirstName LastName

Relationship: Son

Address: 333 Street Address

City, Virginia 11111

Phone: 1111111111

Email: emailaddress@email.com

as my successor agent to serve in that capacity.

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. My agent's authority hereunder is effective as long as I am incapable of making an informed decision.

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 make any decision regarding my health care 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 health care 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.

Powers of My Agent

Unless I state otherwise in the below section limiting the powers of my agent, the powers of my agent shall include the following:

A. To consent to or refuse or withdraw consent to any type of health 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 of inadvertently hastening 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, assisted living facility or other medical care facility. If I have authorized admission to a health care facility for treatment of mental illness, that authority is stated elsewhere in this advance directive;

E. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days provided I do not protest the admission and a physician

on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness and I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility;

F. To continue to serve as my agent even in the event that I protest the agent's authority after I have been determined to be incapable of making an informed decision;

G. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that offers the prospect of direct therapeutic benefit to me;

H. To authorize my participation in any health care study approved by an institutional review board or research review committee pursuant to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me;

I. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions; and

J. 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 health care pursuant to his authorization, based solely on that authorization.

LIMITATIONS ON MY AGENT'S POWERS

I do not wish to limit the authority of my health care agent at this time.

HEALTH CARE INSTRUCTIONS

A. I specifically direct that I receive the following health care if it is medically appropriate under the circumstances as determined by my attending physician: I do not wish to leave instructions for specific health care I want to receive.

B. I specifically direct that the following health care not be provided to me under the following circumstances (you may specify that certain health care not be provided under any circumstances): I do not wish to leave instructions for specific health care I do not want to receive.

END OF LIFE INSTRUCTIONS

1. Terminal Condition:

_____☑ If at any time my attending physician should determine that I have a terminal condition where the application of life-prolonging procedures-including artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition, and

artificially administered hydration-would serve only to artificially prolong the dying process, I DO NOT want life-prolonging procedures and 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.

☐ If at any time my attending physician should determine that I have a terminal condition, I DO want life-prolonging procedures to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable.

2. Persistent Vegetative State:

_____☑ If at any time I am in a persistent vegetative state where my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment, I DO NOT want life-prolonging treatment and direct that such procedures-including artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition, and artificially administered hydration-be withheld or withdrawn 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.

☐ If at any time I am in a persistent vegetative state, I DO want life-prolonging procedures to prolong my life as long as possible within the limits of generally accepted health care standard. I understand that I will receive treatment to relieve pain and make me comfortable.

OTHER DIRECTIONS ABOUT LIFE-PROLONGING PROCEDURES

I do not wish to leave other directions at this time.

ANATOMICAL GIFT

Upon my death, I direct:

_____☑ I donate my whole body

☐ I donate my organs, eyes, and tissue

☐ I donate only the following organs and tissue I specify:

☐ I do not want to donate any organs, eyes, or tissue.

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I indicate that I am emotionally and mentally capable of making this directive and that I understand the purpose and effect of this document. I understand I may revoke all or any part of this document at any time by:

- A signed and dated writing
- Physical cancellation or destruction of this directive by myself or by directing someone else to destroy it in my presence
- My oral expression of intent to revoke

My Signature: ______________________________ Date: _________________________

Printed Name: ______________________________

Witnesses:

The declarant, **FirstName LastName**, signed the foregoing in my presence on ______________ ____________.

Witness Signature: __________________________

Printed Name: ______________________________

Witness Signature: __________________________

Printed Name: ______________________________