ADVANCE DIRECTIVE
(LIVING WILL & MEDICAL POWER OF ATTORNEY)
OF NANCY ANN SIANCY

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(Virginia, Maryland, and DC)

I, **Nancy Ann Siancy,** currently residing at 12345 Dignity Lane, Natural Death, Virginia 20112 and being an adult of sound mind, willfully and voluntarily write this document intending it to be recognized as my Advance Directive, Living Will, and Medical Power of Attorney. Nothing in this document shall be construed to condone, authorize, or approve mercy-killing or to permit any affirmative or deliberate act to end my life other than to permit the natural process of dying.

A. DEFINITIONS.

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For purposes of this document, all terms used herein shall be interpreted in conformity with the Virginia Health Care Decisions Act (Virginia Code Title 54.1, Chap. 29, Art. 8), the Maryland Health Care Decisions Act (Maryland Code Title 5, Subtitle 6), and the District of Columbia Health-Care Decisions Act (DC Code Div. III, Title 21, Chap. 22).

1. "**Agent**" means the then-serving individual or individuals whom I have named in Section E of this document. My Agent may also be referred to as my Medical Attorney-in-Fact or Health Care Agent.
2. "**Attending physician**" means the physician who has primary responsibility for my treatment and care.

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3. "**End-stage condition**" means an advanced, progressive, irreversible condition caused by injury, disease, or illness: (1) that has caused severe and permanent deterioration indicated by incompetency and complete physical dependency; and (2) for which, to a reasonable degree of medical probability, treatment of the irreversible condition would be **medically ineffective**.
4. "**Incapable of making an informed decision**" means that I am unable to understand the nature, extent or probable consequences of a proposed medical decision, or unable to make a rational evaluation of the risks and benefits of the proposed decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way. The determination that I am incapable of making an informed decision shall be made by two licensed physicians qualified to make a determination of mental incapacity (one of whom may be my attending physician and one of whom shall be a psychiatrist) after a personal examination of me, and shall be certified in writing, such certification to 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.

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5. "**Life-prolonging procedure**" means any medical procedure, treatment or intervention which (a) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function, or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (b) when applied to a patient in a terminal condition, would serve only to prolong the dying process. Examples of life-prolonging procedures include, without limitation: surgery; medications (including any and all drugs, medications, vitamins, minerals, or antibiotics, whether prescribed or not); cardiopulmonary resuscitation; artificial respiratory and circulatory aids such as respirators, ventilators, or the administration of oxygen; blood transfusion; chemo-therapy; dialysis; and artificially administered hydration and nutrition. If there are any types of life-prolonging procedures listed above that I do not want withheld or withdrawn from me, I have crossed those out and initialed in the adjoining margin. The term "life-prolonging

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procedures" does not apply to the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain, including the administration of pain relieving medications in excess of recommended dosages.

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6. "**Long-Term Care"** refers to the broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to a chronic illness or disabling condition, and who are expected to need such services over a prolonged period of time. Long-term care can consist of care in the home by family members who are assisted with voluntary or employed help, adult day health care, or care in assisted living facilities or skilled nursing facilities (*i.e.,* nursing homes).

7. "**Medically ineffective"** treatment means treatment that, to a reasonable degree of medical probability, will not: (1) prevent or reduce the deterioration of the health of an individual or (2) prevent the impending death of an individual.

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8. "**Persistent vegetative state**" means a condition in which a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person cannot think or respond.

9. "**Physician**" means a person licensed to practice medicine in the State or in the jurisdiction where the treatment is to be rendered or withheld.

10. "**Terminal condition**" means a condition caused by injury, disease or illness from which, to a reasonable degree of medical probability, I cannot recover; such that either (a) my death is imminent or (b) I am in a **persistent vegetative state** or (c) I am in an **end-stage condition**.

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B. IF MY CONDITION IS TERMINAL.

If at any time I am suffering from a terminal condition (as defined in Section A.10) and the only thing holding me to this life is, or would be, the application of life-prolonging procedures (as defined in Section A.5) that serve only to artificially prolong the dying process, I direct that the actions taken by my family, physicians, and all those concerned with my care be controlled by the following declaration that I have initialed (initial one):

_____ I want to be permitted to die naturally, and I do not want life-prolonging procedures. If life-prolonging procedures are started, I want them stopped.

_____ I want life-prolonging procedures to be started as necessary and I want my Agent and other family members to be advised of my condition or change in condition as soon as possible thereafter. If there is no significant improvement in my condition after what my Agent considers a reasonable length of time, I would like my Agent at that time to direct my physicians to discontinue further life-prolonging procedures, permitting me to die naturally.

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_____ I want life-prolonging procedures to the extent that my Agent, after consulting with my physicians, thinks they are appropriate for me.

_____ I want all available medical treatment. No matter what my condition is, I want to be given all available medical treatment in accordance with accepted health care standards. Evaluation of my future "quality of life" is not to be a factor.

_____ I have no preference regarding the use of life-prolonging procedures.

_____ Other: ____

____.

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C. PAIN RELIEF WHEN I AM SUFFERING FROM A TERMINAL CONDITION.

If at any time I am suffering from a terminal condition (as defined in Section A.10):

_____ I want appropriate medication and medical procedures to keep me as comfortable and as free from pain as possible, and to relieve pain and suffering, even if such medication and/or medical procedures would shorten my remaining life.

_____ I want no medication or medical procedures to relieve pain and suffering if it would shorten my remaining life.

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D. DESIGNATION OF AGENT(S).

I hereby appoint my spouse:

John M. Siancy — Home: 703-555-1111
12345 Dignity Lane — Work: 703-555-2222
Natural Death, Virginia 20112 — Cell: 703-555-3333

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as my Agent. If John M. Siancy is not reasonably available or is unable or unwilling to act as my Agent, then I appoint and authorize my brother:

Ronald McLean — Home: 703-555-4444
23456 Main Street — Work: 703-555-5555
Fairfax, Virginia 22030 — Cell: 703-555-6666

as my Agent. If Ronald McLean is not reasonably available or is unable or unwilling to act as my Agent, then I appoint and authorize my mother:

Mildred J. McLean — Home: 703-555-7777
34567 Braddock Road — Work: 703-555-8888
Chantilly, Virginia — Cell: 703-555-9999

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as my Agent.

E. PREFERENCES REGARDING LONG-TERM CARE

If at any time it has been determined that I am incapable of making an informed decision (as defined in Section A.4) and I am in need of long-term care (as defined in Section A.6), I request that my Agent give primary consideration to my desires regarding my care and placement as I have indicated below:

1. If Skilled Nursing Care is Not Required: ***(initial one if desired)***

   _____ I would prefer to remain in my home and receive home-based care as long as possible, regardless of cost, even if it might drastically reduce or entirely deplete my estate.

   Sample Document

   _____ I would prefer to remain in my home and receive home-based care as long as is reasonably possible, but I would prefer not to drastically reduce or entirely deplete my estate.

   _____ I would prefer to live in an Assisted Living Facility so long as the level of care provided is appropriate for my condition.

   _____ Other: ____
   ____.

2. If Skilled Nursing Care is Required and my condition is such that I absolutely must be placed in a nursing home: ***(initial one if desired)***

   _____ I would want to protect as much of my assets as can be legally protected so that I can qualify for publicly-funded Medicaid benefits. I would like the money that has been protected to be used primarily to increase my quality of care (for example, by hiring a private health aide to assist me at the nursing home).

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_____ I would want to protect as much of my assets as can be legally protected so that I can qualify for publicly-funded Medicaid benefits. I would like the money that has been protected to provide an inheritance for the beneficiaries of my estate.

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_____ I would want to pay privately for my nursing home care as long as possible, and not protect any assets to improve my quality of care or to provide an inheritance for the beneficiaries of my estate.

_____ Other: ____
____.

F. When Agent May Act

1. I hereby revoke any medical power of attorney, health care power of attorney, health care appointment of agent, health care proxy, advance medical directive, or similar document at any time previously made by me. This revocation shall not apply to any living will that I have executed simultaneously with the execution of this instrument.

Sample Document

2. My Agent's authority under this instrument shall commence: ***(initial one)***

   _____ Only if I have been certified to be incapable of making an informed decision (defined in Section A.4) or I have executed a certificate stating that from and after its date of execution my Agent is fully authorized to act under this instrument.

   _____ Immediately upon my signing of this document.

3. Once said authority has commenced, my Agent's authority shall remain effective unless and until it is deemed that I have regained the capability of making an informed decision. I will be deemed, for the purposes of this instrument, to have regained the ability to make an informed decision if there is a finding to that effect by a court of competent jurisdiction or upon presentation to my Agent of a certificate executed by two licensed physicians, one of whom is not my attending physician and who is certified or licensed in a medical specialty which signifies special training or experience in determinations of this nature, which states the opinion of such physicians that I am capable of caring for myself or that I am physically and mentally capable of making an informed decision. A certified copy of the order or decree declaring my capacity or the certificate of the physicians described above shall be attached to the original of this instrument (and photocopies thereof shall be attached to photocopies of this instrument) and, if this instrument is filed or recorded among public or private hospital records, then such order, decree, or certificate shall also be similarly filed or recorded.

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4. If this document becomes effective because I am unable to make an informed decision, and subsequently I regain the ability to make an informed decision, as evidenced in the manner provided above, this document shall not be revoked, but shall become effective again upon my subsequent disability or incapacity as provided above or upon my subsequent certification that such power shall be or has become effective.

Sample Document

5. Provided the above conditions are met, the authority of my Agent shall be effective regardless of whether my condition is terminal. However, my Agent shall not have the authority to consent to or take any action that would be inconsistent with my explicit desires as expressed above in Section B of this document.

G. HIPAA Release Authority

I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of individually identifiable health information or other medical records. This release authority applies to any and all information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164. I specifically authorize any physician, healthcare professional, health plan, hospital, clinic, laboratory, pharmacy, dentist, or other covered health care provider or insurance company, and the Medical Information Bureau, Inc. or any other health care clearinghouse (whether said person or entity has

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provided treatment or services to me or has paid for or is seeking payment from me for such services), to give, disclose, and release, without restriction, all of my individually identifiable health information and medical records (including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse), regarding any past, present, or future medical or mental health condition, to:

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1. My Agent named above;
2. Any and all successor Agents named above, even when not serving as my Agent; and
3. The following additional individuals: My children, Jill M. Siancy and John D. Siancy .

This release authority is effective immediately upon the execution of this document (notwithstanding the fact that the rest of my Agent's authority under this document may become effective only upon certification pursuant to Section G, H above), supersedes any prior agreement that I may have made with, or restriction that I may have given to, any health care provider to restrict access to or disclosure of my individually identifiable health information and/or medical records. This release authority has no expiration date and shall terminate as to a given health care provider only in the event that I revoke this release authority in writing and have such written revocation delivered to such health care provider.

Sample Document

H. POWERS OF AGENT

My Agent, when acting pursuant to Section G, H above, shall have the same authority to make health care decisions for me as I would have if I were capable of making my own informed decision. My Agent shall not, by virtue of this authorization, be liable for the costs of treatment rendered in following this authorization.

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My Agent shall have the power and authorization to take any lawful action that may be necessary to carry out these decisions, including, without limitation, the following specific powers ***(strike through any powers you do not wish your Agent to have)***:

1. To consent to, refuse, or withdraw consent to any or all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function including, without limitation, life-prolonging procedures, keeping in mind that my Agent shall not have the authority to consent to or take any action that would be inconsistent with my explicit desires as expressed above in Section B of this document.
2. To consent to the administration of pain-relieving medications in dosages in excess of standard dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastens my death.
3. To consent to, refuse, or withdraw consent to visitation of me by my family and friends.
4. To direct and consent to the writing of, by any health care provider, *No Code* orders, *Do Not Resuscitate* orders, *Durable Do Not Resuscitate* orders and *Emergency Medical Services Do Not Resuscitate* orders.
5. To authorize my admission and/or discharge (including transfer to another facility and/or discharge from a medical facility against medical advice) from any hospital, hospice, nursing home, adult home, or other medical care facility, and to execute on my behalf all documents pertaining to a refusal to permit medical treatment, or any necessary waiver or release from liability required by a physician or health care provider.
6. To communicate medical decisions, medical information, and personal information about me and my medical condition to my attending physician and all other health care providers.
7. To communicate medical decisions, medical information, and personal information about me and my medical condition to members of my family. This power shall not be interpreted as requiring my Agent to communicate any medical decisions, medical

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information, and personal information about me and my medical condition to any specific members of my family.

8. To communicate medical decisions, medical information, and personal information about me and my medical condition to interested persons other than health care providers or family members, such as my close personal friends. This power shall not be interpreted as requiring my Agent to communicate medical decisions, medical information, and personal information about me and my medical condition to any such persons.

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In exercising the above powers, my Agent shall be guided by the decisions I have set forth above.

I. INFORMATION TO ASSIST MY AGENT

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 my Agent 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 the choice I would have made on my own behalf, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interest. I understand that it is my responsibility to communicate any information about my religious beliefs, basic values, and medical care preferences to my Agent in advance, to the extent that I wish them to be followed. To that end, I may attach to this document a separate writing giving such information to my Agent.

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J. AFTER MY DEATH.

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After my death, I direct that my Agent and my family, physicians, and all those concerned with my care shall be guided by the following declarations that I have initialed:

Organ Donation ***(initial all that apply)***

____ If any of my tissue or organs would be of value for transplant, I freely give my permission for the donation of such tissue or organs for:

_____ Transplant

_____ Therapy

_____ Medical or educational uses

_____ Any purpose authorized by law.

_____ I wish to donate any of my organs or tissues for transplant, but only to a blood relative.

_____ I wish to donate only the following organs or tissues for transplant: _______________

____

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_____ I do not wish to donate any of my organs or tissues for any purposes.

_____ I have no preference regarding organ or tissue donation and I authorize my Agent to make this decision.

_____ Other: ____

Autopsy ***(initial one)***

_____ I request an autopsy so my family will be assured of the cause of my death.

_____ I agree to an autopsy if my Agent thinks it warranted.

_____ I do not want an autopsy under any circumstances, unless required under existing law.

_____ I have no preference regarding autopsy and I authorize my Agent to make this decision.

_____ Other: ____

Disposition of Remains ***(initial one)***

_____ I would like to be buried at: ____

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_____ I would like to be buried, but have no specific request as to location.

_____ I would like to be cremated and have my ashes disposed of as follows: ____________
____

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_____ I would like to be cremated, but have no specific request as to disposition of my ashes.

_____ I have no preference regarding burial, cremation, or disposition of my remains, and I authorize my Agent to make this decision.

_____ Other: ____

Type of Service ***(initial all that apply)***

_____ Funeral service: _____Open casket _____ Closed casket

_____ Memorial service.

_____ Graveside service.

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_____ Home service.

_____ I have no preference regarding type of service and authorize my Agent to make this decision.

_____ Other: ____

Location of Service ***(initial all that apply)***

_____ Specific place of worship: ____

_____ The place of worship of which I am a member at the time of my death, or that I regularly attended for at least twelve months prior to my death.

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_____ Any place of worship of the following religion/denomination: ____________________

_____ Funeral or cemetery chapel: _______________________________________

_____ Graveside

_____ I have no preference regarding location and authorize my Agent to make this decision.

_____ Other: ____

Size of Service ***(initial one)***

_____ Open to all who wish to attend.

_____ Family only.

_____ I have no preference regarding this issue and I authorize my Agent to make this decision.

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_____ Other: ____

SIGNATURE.

I sign this instrument as my free and voluntary act, fully understanding its purpose and effect, on this day, October 17, 2006. I may from time to time alter the face of this document to update the addresses and/or telephone numbers of my Agents set forth above, and such alterations shall not in any way affect the validity of this document. Photocopies or facsimiles of this document shall have the same force and effect as the original; and any person, firm, institution, corporation, or

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other entity may rely on this writing until receipt of actual knowledge that I have revoked it. The authorization given pursuant to this document shall not terminate in the event of my disability.

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____
Nancy Ann Siancy

WITNESS:

I, Witness One and Witness Two, each hereby attest and declare under penalty of perjury under the laws of Virginia that: (1) the foregoing instrument was personally signed or acknowledged by Nancy Ann Siancy in my presence; (2) to the best of my knowledge and belief I am not going to receive any portion of the estate of Nancy Ann Siancy upon his death; (3) I do not have any financial responsibility for the medical care of Nancy Ann Siancy; (4) I am not a person named as Agent in this instrument; and (5) I am at least 18 years of age.

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____
Witness One
Street
City, Virginia Zip

____
Witness Two
Street
City, Virginia Zip

COMMONWEALTH OF VIRGINIA
CITY OF FAIRFAX } TO-WIT:

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SUBSCRIBED, SWORN TO, AND ACKNOWLEDGED before me by the said Nancy Ann Siancy, and SUBSCRIBED AND SWORN TO before me by the said Witness One and Witness Two, as witnesses, on this day, October 17, 2006.

____
EVAN H. FARR, Notary Public
My commission expires: August 31, 2007.

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REGISTRATION AGREEMENT FOR YOUR ADVANCE DIRECTIVE
(LIVING WILL & MEDICAL POWER OF ATTORNEY)
ID #55111500

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- Please read this REGISTRATION AGREEMENT carefully and make sure that all the identifying information we have filled in is correct.
- If you choose to register your Medical Power of Attorney, you must sign this REGISTRATION AGREEMENT at the time you sign your Medical Power of Attorney. By signing, you will be requesting registration of your Medical Power of Attorney with the U.S. Living Will Registry.
- Once your Medical Power of Attorney has been signed, we will make a copy and send it to the Registry for you at no charge.
- Registration for you is **free**. We provide this service to you without charge through an annual fee that this firm pays to the U.S. Living Will Registry.

Sample Document

IDENTIFYING INFORMATION

Full Legal Name: Nancy Ann Siancy
Social Security Number: 123-45-6789
Date of Birth: 01-01-1960
Address: • Primary Residence: 12345 Dignity Lane
Natural Death, Virginia 20112
• Secondary Residence: ______________________________ Apt #_____
(if any) *(Street Address)*
____
(City) *(State)* *(Zip)*

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Telephone Number: Home: 703-691-1691
Work: 703-691-1888

Emergency Contact:

Relationship to Registrant: **Spouse**

John M. Siancy — Home: 703-555-1111
12345 Dignity Lane — Work: 703-555-2222
Natural Death, Virginia 20112 — Cell: 703-555-3333

I, **Nancy Ann Siancy,** ("Registrant"), request that the U.S. Living Will Registry®, with offices at 523 Westfield Ave., PO Box 2789, Westfield, New Jersey 07091-2789 (the "Registry"), electronically store a copy of my attached Medical Power of Attorney (collectively, including but not limited to my living will, health care proxy, or similar document, including organ donor information, provided to the Registry), and provide a copy of the stored Medical Power of Attorney to any health care provider who requests it in conjunction with my care. A "health care provider" is any hospital, doctor, skilled nursing facility, nursing facility, home health care agency or provider, ambulatory surgery facility, hospice, or any authorized employee, contractor, or agent of any of the foregoing, or other person believed charged with giving effect to my Medical Power of Attorney or assisting in same. I voluntarily execute this registration on the date set forth below, without coercion, duress, or undue influence from any party, and I warrant and represent that I have the legal capacity to offer my consent to such registration. My registration is not effective until I receive written confirmation from the Registry, at the above address. I can only register through a Registry member Health Care Provider or a Registry Community Partner. The Registry's member Health Care Providers and Community Partners are not owned or operated by the Registry, and they cannot change any terms of this Registration Agreement; any oral changes are not effective. Only the Registry can change the terms of the Registration Agreement, and only in writing (except in emergencies, in the Registry's sole discretion). I have provided my Social Security number to facilitate the identification, retrieval, and provision of my stored advance directive images to health care providers, and for the Registry's record keeping purposes only.

Sample Document

I. Registration and Certification: The information is submitted to confirm my identity, in case a health care provider requests a copy of my Medical Power of Attorney. I certify that the information submitted is correct and further certify that the Medical Power of Attorney which accompanies this Registration Agreement is my currently effective Medical Power of Attorney and was duly executed, witnessed and acknowledged in accordance with the laws of the state of Virginia. If the Medical Power of Attorney submitted with this Registration Agreement is a copy, I hereby certify that it is a true and correct copy of the original document.

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I agree to immediately notify the Registry, in writing, at the Registry's address listed above, in the event of my revocation of the attached Medical Power of Attorney or of this registration, or if the attached Medical Power of Attorney or the identifying information herein are changed in any way. I agree immediately to provide the Registry with a copy of the new/changed documents. I will indemnify and hold the Registry harmless for any damages resulting from the Registry's reliance on these certifications, or on any inaccurate information I supplied. If I don't notify the Registry in writing and in a timely manner of any changes, or of the revocation of my advance directive or this registration, or if I don't provide a true copy of the changed documents to the Registry, the Registry will not be liable for any damages resulting from the production of the documents on file to any health care provider.

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If my information is accessed over the Internet using my unique registration number, my social security number ("SSN") will not be revealed, and it will not be visible or disclosed on the Registry's web page. If the card containing my unique registration number is lost or otherwise unavailable, health care providers will be able to access my documents using my SSN. I understand that since most health care providers have access to their patients' SSNs, providing my SSN to the Registry ensures the widest available of my Medical Power of Attorney image to health care providers in time of need, even when my card is not available. The Registry has stated that it will take appropriate steps to safeguard the privacy and confidentiality of my SSN, and will not use my SSN for any purpose not specifically permitted by this Registration Agreement. If I do not provide my SSN, my documents will be identified only by the unique registration number assigned by the Registry, which will significantly limit the accessibility of my documents.

Sample Document

II. Authorization: I hereby authorize the Registry to send a copy of my Medical Power of Attorney to any health care provider (as defined herein) that requests a copy of such Medical Power of Attorney, provided the request conforms to the Registry's policies and procedures, or as deemed advisable by the Registry in an emergency situation, or as required by law). The Registry is not otherwise authorized to share my personal information with parties other than health care providers. A copy of this Agreement may be used in place of the original document.

III. Limitations on Liability: I understand I will not be charged a fee to register or to maintain my registration. The Registry shall not be liable to me or to any person or entity for any liability arising from the improper transmission or disclosure of my Medical Power of Attorney, from the transmission of inaccurate or incomplete materials, or from the loss, misplacement, destruction, or unavailability of all or part of my Medical Power of Attorney. If I do not agree to these terms, I am free not to use the Registry's service.

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IV. Term. This Agreement shall remain in effect until Registry receives reliable information that the Registrant is deceased, or until the Registrant requests, in writing, that the Agreement be terminated, or until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, Registry will use its best efforts to remove Registrant's Medical Power of Attorney from its files.

I hereby agree to the terms herein, and certify the accuracy of the information provided. I agree to safeguard my Registration ID card from unauthorized access. I understand that anyone who gains access to my card can use it to gain access to my documents and personal information (but not to my SSN), and I will not hold the Registry liable for such unauthorized access.

Dated October 17, 2006 ____

Nancy Ann Siancy

Sample Document

WITNESS STATEMENT

I declare that the Registrant who signed this document is personally known to me, that he/she signed or acknowledged this document in my presence, and that he/she appears to be of sound mind and under no duress or undue influence.

________________________	________________________
Witness One	Witness Two
Street	Street
City, Virginia Zip	City, Virginia Zip

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AUTHORIZATION ALLOWING LIMITED RELEASE OF MEDICAL POWER OF ATTORNEY

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TO: The Law Firm of Evan H. Farr, P.C.

FROM: Nancy Ann Siancy

I, Nancy Ann Siancy, do hereby authorize the above-named law firm to release a copy of my Medical Power of Attorney dated October 17, 2006, to any of the persons listed below, upon determination that I am incapable of managing my own personal and medical affairs:

Name	Relationship

Sample Document

The determination that I am incapable of managing my own personal and medical affairs may be made by two physicians (or one physician and one licensed clinical psychologist) after a personal examination of me, and shall be certified in a sworn written affidavit (or certified true copy of such sworn written affidavit). The determination that I am incapable of managing my own personal and medical affairs may also be made by a court of competent jurisdiction.

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A photocopy of this document shall have the same force and effect of an original, and the authority granted herein shall continue in force and effect unless specifically revoked by me in a writing delivered to the above-named law firm.

Dated: October 17, 2006 ______________________________

Nancy Ann Siancy

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ATTACHMENT TO ADVANCE MEDICAL DIRECTIVE: QUESTIONS AND HYPOTHETICAL SCENARIOS

In order to have the most effective Advance Medical Directive, you should give a copy to your Agent and share your wishes and values with your Agent. You may also want to discuss its content with your physician and family.

Below is a list of hypothetical scenarios and questions you may find helpful for identifying and addressing with your Agent the most significant issues in connection with your Advance Medical Directive. You may want to provide written answers to the questions and hypothetical scenarios presented (either below or in a separate document) and give a copy to your Agent, or you may just want to discuss the questions and hypothetical scenarios with your Agent.

HYPOTHETICAL SCENARIOS

1. Alzheimer's Disease Or Other Dementia

You have Alzheimer's disease or another type of dementia, which has progressed to the point where you do not recognize your loved ones, and spoon-feeding is no longer possible. Would you want to be fed by tube? ❒ Yes ❒ No ❒ Uncertain

2. Chemotherapy and Less than 1% Chance of Recovery

You are seriously ill, and the chemotherapy recommended by doctors has severe side effects such as pain, nausea, vomiting, and weakness, that could last for two to three months. Would you want to endure the side effects if your chance of regaining your current health was less than 1%?
❒ Yes ❒ No ❒ Uncertain

3. Chemotherapy and Terminal Condition

Your condition is clearly terminal, but the chemotherapy with severe side effects (pain, nausea, vomiting, and weakness) might give you 6 additional months of life. Would you want the chemotherapy? ❒ Yes ❒ No ❒ Uncertain

4. Dementia and Gangrene

You have moderate dementia causing mental confusion, but about half the time you recognize and interact with friends and loved ones on a simple level. If you develop gangrene in a leg, and doctors recommend amputation because the condition could be fatal, would you want the operation? ❒ Yes ❒ No ❒ Uncertain

5. Dementia and Recurring Bouts of Pneumonia

You are living in a nursing home and have moderate dementia causing mental confusion, but about half the time you recognize and interact with friends and loved ones on a simple level. Physically, you are very frail and need help with most routine daily activities such as bathing, eating, and going to the toilet. In addition, you have had recurring bouts of pneumonia or lung infections four times in the past year, each time causing you to be hospitalized for several days. In the hospital, you receive breathing support through a respirator and antibiotics through an intravenous tube until you are well enough to be returned to the nursing home. The next time you get pneumonia, do you want respiratory support and antibiotic treatment, or do you want comfort care only? ❑ Respiratory Support and Antibiotic treatment ❑ Comfort care only
❑ Uncertain

YOUR PRIORITIES

1. **Your concerns about your health or future health care.**

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2. **Your feelings regarding the end of life.**

3. **Your values regarding your physical and/or mental well being: both the <u>ability</u> to see, taste, touch, read, listen to music, be aware of your surroundings, be independent, etc., and the <u>extent</u> to which you are able to use the ability.**

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4. **Your preferences regarding long-term care – assisted living, nursing home care, or home-based care.**

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5. **Your preferences regarding hospice care.**

6. **If you could plan it today, what would the last day or week of your life be like?**
   a. Where? In a hospital? A special place? At home?
   b. Who should be present?
   c. What would you like to be doing?
   d. If you can eat, what would you like to eat?
   e. What would your final works or last acts be?

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7. **At the end of your life, you prefer that:**
   a. Your specific preferences are followed, even if there is disagreement among your family or friends.
   b. Your family and friends are all in agreement, even if the course they choose is not your specific preference.
   c. Uncertain

YOUR SPIRITUALITY AND YOUR FUNERAL

1. **What gives purpose and meaning to your life?**

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2. What should others know about your spirituality?

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3. What beliefs do you hold that influence your thoughts about life and about dying?

4. How do you want to be remembered (if you were writing your own epitaph or obituary, what would it say)?

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5. What are your wishes for a funeral or memorial service (songs, readings, people you hope will participate)?

YOUR CONCERNS

1. Are you concerned about being in pain at the time of your death?

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❒ Yes ❒ No ❒ Uncertain

2. Are you concerned about losing the ability to think?

❒ Yes ❒ No ❒ Uncertain

3. Are you concerned about losing your memory?

❒ Yes ❒ No ❒ Uncertain

4. Are you concerned about being a financial and/or emotional burden on loved ones?

❒ Yes ❒ No ❒ Uncertain

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