DRAFT

Prepared by **FARR LAW FIRM**,
10640 Main Street, Suite 200, Fairfax, Virginia 22030
Copyright by Farr Law Firm

THE 4 NEEDS ADVANCE MEDICAL DIRECTIVE® OF ADAM TESTCASE

1. MEDICAL POWER OF ATTORNEY	3. NEAR-DEATH DIRECTIVE
2. LONG-TERM CARE DIRECTIVE®	4. AFTER-DEATH DIRECTIVE

I, **Adam Testcase**, currently residing at 123 Test Street, Fairfax, Virginia 22030, and being an adult of sound mind, willfully and voluntarily write this instrument, intending it to be recognized as my Medical Power of Attorney, Long-Term Care Directive®, Near-Death Directive, and After-Death Directive. Nothing in this instrument 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.

Definitions for terms used in this instrument are set out in Part 5, located immediately behind the signature page. For purposes of this instrument, all terms used herein shall be interpreted in conformity with Virginia Healthcare Decisions Act or the equivalent Act in the State where I am located.

PART 1 MEDICAL POWER OF ATTORNEY

1.1 Designation of Agent(s). I hereby appoint as Agent my wife:

Eve H. Testcase
123 test street
Fairfax, Va 22030
Email: test@testcase.com

Home: 123-456-7891
Work: 123-456-7891
Cell: 123-456-7891

If Eve H. Testcase is not reasonably available or unable or unwilling to act as Agent, then I hereby appoint as Agent my son:

John Testcase
123 Test Street
Fairfax, Va 22030
Email: john@testcase.com

Home: 123-456-7891
Work: 123-456-7891
Cell: 123-456-7891

and my daughter:

Jane Testcase
123 test street
Fairfax, Va 22030
Email: test@testcase.com

Home: 123-456-7891
Work: 123-456-7891
Cell: 123-456-7891

DRAFT

If John Testcase and Eve H. Testcase are both not reasonably available or unable or unwilling to act as Agent, then I appoint as Agent my nephew:

Samuel Testcase
123 Test Street
Fairfax, Va 22030
Email: test@testcase.com

Home: 123-456-7891
Work: 123-456-7891
Cell: 123-456-7891

If Samuel Testcase is not reasonably available or is unable or unwilling to act as my Agent, then I appoint as Agent my sister:

Julie Testcase
123 Test Street
Fairfax, Va 22030
Email: test@testcase.com

Home: 123-456-7891
Work: 123-456-7891
Cell: 123-456-7891

THE REMAINDER OF THIS PAGE IS INTENTENTIONALLY BLANK

DRAFT

1.2 When Agent May Act:

1.2.1 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 instrument at any time previously made by me.

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

_____ Immediately upon my signing of this instrument.

_____ Only if I have been certified to be incapable of making an informed decision (defined in Section 5.5), 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. If I am determined to be incapable of making an informed decision, I shall be notified (to the extent I am capable of receiving such notice) that such determination has been made before health care is provided, continued, withheld, or withdrawn. As soon as practical such notice shall also be provided to my named Agent or person authorized to make health care decisions on my behalf. If I am later determined to be capable of making an informed decision, any further health care decisions will require my informed consent.

1.2.3 If I have authorized my Agent to act immediately, then my Agent's authority shall remain effective unless and until I revoke it.

1.2.4 If I have authorized my Agent to act only if I have been certified to be incapable of making an informed decision, then my Agent's authority shall remain effective unless and until it is deemed that I have regained the capacity to make an informed decision.

1.2.5 If I have named my spouse as my Agent, my spouse's authority to act as my Agent shall remain effective even if one of us brings an action for divorce or for separate maintenance, and even after the conclusion of such action, unless and until I revoke such authority in writing.

1.2.6 For the purposes of this instrument I will be deemed to have regained the capacity 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 of 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 be similarly filed or recorded.

DRAFT

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

1.2.7 The authority of my Agent shall be effective regardless of whether my condition is terminal.

1.2.8 In exercising the power to make health care decisions on my behalf, my Agent shall follow my desires and preferences as stated in this instrument or as otherwise known to my Agent. My Agent shall not have the authority to consent to or take any action that would be inconsistent with my explicit desires as expressed in this instrument. 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 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 what health care choice I would have made on my own behalf, then my Agent shall make a choice for me based upon what my Agent believes is in my best interests.

1.3 Co-Agents:

1.3.1 If I have named two or more individuals to act as Co-Agents, then the signatures and/or agreement of any one of them shall be sufficient to exercise the powers granted hereunder. However, it is my hope and desire that my Co-Agents will consult with each other and reach an agreement prior to making any decisions hereunder.

1.4 Powers of Agent:

1.4.1 **Agent Not Financially Liable**. My Agent shall not be liable, by virtue of this authorization, for the costs of treatment rendered in following this authorization.

1.4.2 **General Powers**. When acting hereunder, my Agent 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. In exercising these powers, my Agent shall be guided by any decisions I have set forth herein and by any information that I may have previously made known to my Agent about my wishes or my general philosophy. 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 and initial any powers you do not wish your Agent to have):

DRAFT

1.4.2.1 To consent to, refuse, or withdraw consent to any or all types of health care including, without limitation, alternative health care and 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 in this instrument.

1.4.2.2 To consent to the administration of pain-relieving medications 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.

1.4.2.3 To request, receive, and review any information (verbal, written, or electronic), regarding my physical or mental health, including but not limited to medical and hospital records; and to consent to the disclosure of this information.

1.4.2.4 To employ and discharge my health care providers.

1.4.2.5 To ban visitation by persons that I have indicated I do not want visiting me, and by persons whom my Agent believes in good faith will agitate me or in some other way worsen my mental or physical condition.

1.4.2.6 To direct and consent to the writing of any orders or instructions that must be issued by a physician or health care provider, including but not limited to *Do Not Resuscitate (DNR)* orders, *Durable Do Not Resuscitate (DDNR)* orders, *Do Not Intubate (DNI)* orders, *No Code* orders, *Emergency Medical Services Do Not Resuscitate (EMSDNR)* orders, *Do Not Hospitalize (DNH)* orders, *Medical Orders for Life-Sustaining Treatment (MOLST), Medical Order for Scope of Treatment (MOST),* and *Physician Orders for Life-Sustaining Treatment (POLST)*.

1.4.2.7 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 all instruments on my behalf pertaining to a refusal to permit medical treatment, including without limitation any waiver or release from liability required by a physician or health care provider.

1.4.2.8 To continue to serve as my Agent even if I protest the Agent's authority, provided that I have been determined to be incapable of making an informed decision.

1.4.2.9 To authorize my participation in any health care or alternative health care study that offers the prospect of direct benefit to me.

1.4.2.10 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.

DRAFT

1.4.2.11 To communicate health care decisions, health care information, and personal information about me and my health care condition to my attending physician and all other health care providers.

1.4.2.12 To communicate health care decisions, health care information, and personal information about me and my health care condition to members of my family. This power shall not be interpreted as requiring my Agent to communicate any health care decisions, health care information, and personal information about me and my health care condition to any specific members of my family.

1.4.2.13 To communicate health care decisions, health care information, and personal information about me and my health care 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 health care decisions, health care information, and personal information about me and my health care condition to any such persons.

1.4.2.14 To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to health care providers. My Agent shall not be personally liable for costs of health care incurred pursuant to my Agent's authorization, if based solely on that authorization.

1.4.2.15 To make all arrangements, both before and after my death, in connection with burial, cremation, and disposition of remains, in accordance with my stated wishes as set forth in this instrument.

1.4.3 **Mental Health Powers.** In addition to all of the General Powers set forth above, my Agent may authorize my admission to or discharge from a mental health care facility for the treatment of mental illness or cognitive impairment provided that:

1.4.3.1 The admission is for not more than ten (10) calendar days; and

1.4.3.2 I do not protest the admission; and

1.4.3.3 A physician on the staff of, or designated by, the proposed facility has examined me and has stated in writing that:

1.4.3.3.1 I have a mental illness or cognitive impairment,

1.4.3.3.2 I am incapable of making an informed decision about my admission, and

1.4.3.3.3 I need treatment in the facility.

1.5 Avoidance of Guardianship. One of my purposes in executing this Advance Medical Directive, specifically Part 1, my Medical Power of Attorney, is to avoid ever needing to have a Guardian appointed for me to make medical decisions. However, if a court decides to appoint a Guardian for me, I hereby nominate my agent(s) named above, in the order named, to serve as my Guardian(s).

DRAFT

1.6 ADDITIONAL INFORMATION TO ASSIST MY AGENT. I understand that it is my responsibility to communicate any information about my religious beliefs, basic values, and health care preferences to my Agent in advance, to the extent that I wish them to be followed. To that end, I make certain wishes known below and I may attach to this instrument a separate writing giving additional information to my Agent which I request my Agent to honor.

1.6.1 **During a Pandemic:** During any such time as there exists a worldwide pandemic (as declared by the World Health Organization), I direct that the actions taken by my Agent, family, physicians, health care providers, and all those concerned with my care be controlled by the following declarations that I have initialed ***(initial only one)***:

_____If my physicians believe there is a chance for me to recover from the illness and return to a reasonably normal life, I want *all available health care treatment* in accordance with accepted health care standards, including experimental and untested treatments if deemed appropriate under the circumstances *(if you initial this option, please also initial one of the two sub-options below);*

_____Evaluation of my future quality of life shall not be taken into consideration.

_____Evaluation of my future quality of life shall be taken into consideration.

_____If my physicians believe there is a chance for me to recover from the illness and return to a reasonably normal life, I want *all reasonably available health care treatments* in accordance with accepted health care standards, but I do not want experimental and untested treatments (*if you initial this option, please also initial one of the two sub-options below)*;

_____Evaluation of my future quality of life shall not be taken into consideration.

_____Evaluation of my future quality of life shall be taken into consideration.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY BLANK

DRAFT

Exceptions in the Event of a Pandemic *(initial all that apply)*:

_____Even if my physicians believe there is a chance for me to recover from the illness, I would not want to be intubated and placed on a ventilator under any circumstances.

_____If my physicians believe there is a chance for me to recover from the illness, I would want to be placed on a ventilator, but I would want the ventilator discontinued if I reach the point where I also need a feeding tube inserted through a hole into my stomach.

_____If my physicians believe there is a chance for me to recover from the illness, I would want to be placed on a ventilator, but I would want the ventilator discontinued if I reach the point where I also need kidney dialysis.

_____Even if my physicians believe there is a chance for me to recover from the illness, I would not want to be intubated and placed on a ventilator if there is a limited supply of ventilators and that limited supply can be used to treat other people.

_____Even if my physicians believe there is a chance for me to recover from the illness, I would not want to be placed on kidney dialysis if there is a limited supply of dialysis machines and that limited supply can be used to treat other people.

_____Even if my physicians believe there is a chance for me to recover from the illness, I would not want to be placed on kidney dialysis.

_____Even if my physicians believe there is a chance for me to recover from the illness, I would not want to be resuscitated by having electric shock applied to my chest.

_____Even if my physicians believe there is a chance for me to recover from the illness, I would not want to be resuscitated by having chest compressions that could break my ribs.

_____Even if my physicians believe there is a chance for me to recover from the illness, I would not want be placed on a feeding tube of any type for hydration or nutrition.

_____Even if my physicians believe there is a chance for me to recover from the illness, I would not want be placed on a feeding tube inserted through a hole into my stomach.

_____Even if my physicians believe there is a chance for me to recover from the illness, I would not want blood, plasma, or platelet transfusions.

_____Even if my physicians believe there is a chance for me to recover from the illness, 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 after a reasonable trial period, with the exception only of any procedure necessary to provide me with comfort care or to alleviate pain.

DRAFT

1.7 HIPAA Release Authority:

1.7.1 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 U.S.C. 1320d, and 45 C.F.R. 160-164. I specifically authorize all doctors (including but not limited to physicians, podiatrists, chiropractors, osteopaths, psychiatrists, psychologists, and dentists), therapists, nurses, hospitals, clinics, pharmacies, laboratories, ambulance services, assisted living facilities, residential care facilities, bed and board facilities, nursing homes, hospice providers, insurance companies, medical information bureaus (whether said person or entity has provided treatment or services to me or has paid for or is seeking payment from me for such services), or any other health care providers or affiliates that have my Protected Health Information, 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 my Agent named above and any and all successor Agents named above, even when not serving as my Agent.

1.7.2 This release authority is effective immediately upon the execution of this instrument (notwithstanding the fact that the rest of my Agent's authority under this instrument may become effective only upon certification pursuant to Section 1.2 above). This release authority shall expire three (3) years after my death and shall terminate sooner as to a given health care provider only if I revoke this release authority in writing and have such written revocation delivered to such health care provider.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY BLANK

DRAFT

PART 2 LONG-TERM CARE DIRECTIVE®

2.1 PREFERENCES REGARDING LONG-TERM CARE:

2.1.1 If at any time it has been determined that I am incapable of making an informed decision (as defined in Section 5.5 of my Advance Medical Directive) and it has been determined that I am in need of long-term care (as defined in Section 5.7 of my Advance Medical Directive), it is my intention that this statement be honored by my family and physicians as the expression of my legal right to direct my own long-term care decision making and my acceptance of the consequences of such direction.

2.1.2 ***Unless I have initialed one or more "Alternate Long-Term Care Wishes" below that contradict the following wishes, then my long-term care wishes are as follows:***

2.1.2.1 If I do not require Nursing Home care, I would like to remain at home and receive home-based long-term care as long as reasonably possible, giving due consideration to the ability of my financial assets to support such in-home care; if my medical condition makes me eligible to receive financial aid for such in-home care through programs such as Medicaid or Veterans Aid & Attendance, I would like my Agent hereunder to cooperate with my Agent under Power of Attorney in working with a qualified Elder Law Attorney to protect my assets in order to secure such financial aid.

2.1.2.2 If I do require Nursing Home care, I would like my Agent hereunder to cooperate with my Agent under Power of Attorney in working with a qualified Elder Law Attorney to protect the greatest amount of my assets as can be legally protected so that I can qualify as quickly as possible for Medicaid benefits. I would like the assets that have been protected to be used primarily to preserve my dignity and quality of life (for example, by hiring a private sitter to assist me at the nursing home, or to purchase assistive devices that Medicaid does not cover, such as dentures, hearing aids, and corrective lenses). To the extent that any protected assets have not been used for my benefit at the time of my death, I would like the remaining assets to provide an inheritance for the beneficiaries of my estate.

2.1.2.3 Regardless of whether I require Nursing Home care, I would like my Agent hereunder to review my answers to the attached Hypothetical Health Care Scenarios found under the Long-Term Care Directive located in the Optional Attachment to the Advance Medical Care Directive, if I have provided answers to same.

2.1.2.4 Regardless of whether I require Nursing Home care, I would like my Agent hereunder to review my Long-Term Care Directive located in the Optional Attachment to the Advance Medical Care Directive, and to give a copy of my Long-Term Care Directive to all of my caregivers, with a view toward using said Long-Term Care Directive to guide my caregivers so that I can get the care that is best for me according to my desires, habits, preferences, etc., as detailed in my Long-Term Care Directive.

DRAFT

2.2 ALTERNATE LONG-TERM CARE WISHES:

2.2.1 If I Do Not Require Nursing Home Care *(initial only one)*:

_____ I would like to remain at home and receive home-based care as long as possible, regardless of cost—even if it entirely depletes my estate.

_____ I would like to remain at home and receive home-based care as long as reasonably possible given my health condition and my finances, and only move to an Assisted Living Community when necessary for my condition.

_____ I would like to remain at home and receive home-based care as long as possible, regardless of cost—even if it entirely depletes my estate—and only move to an Assisted Living Community if it is apparent that I can no longer recognize my loved ones on a consistent basis.

_____ I would like to move to an Assisted Living Community as soon as is appropriate for my condition, as I would prefer the social stimulation and companionship available in an Assisted Living Community versus the social isolation and lack of companionship that I fear would occur if I remain living at home.

If I Do Require Nursing Home Care *(initial only one)*:

_____ I would like to protect the greatest amount of my assets as can be legally protected and qualify for Medicaid benefits, but I would like the money that has been protected to be used primarily to provide an inheritance for the beneficiaries of my estate. I am not concerned with having my protected assets be used to preserve my dignity and quality of life.

_____ I would like to protect the greatest amount of my assets as can be legally protected and qualify for Medicaid benefits, and I would like the money that has been protected to be used to the greatest extent possible to pay for my enhanced care and to pay for items and services that will help to preserve my dignity and quality of life. My having the best quality of life is much more important to me than leaving an inheritance.

_____ I would prefer to pay privately for my nursing home care as long as possible, regardless of cost, even if it might entirely deplete my estate. I am not concerned about improving my quality of life or providing an inheritance for the beneficiaries of my estate.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY BLANK

DRAFT

2.3 DNR Desires:

2.3.1 If I have placed my initials next to a **DNR (Do Not Resuscitate)** option below, it is my intention that my heart should not be restarted should it stop beating on its own. No mechanical compressions, electric defibrillation, or cardiac resuscitative medications shall be administered after my heart stops.

2.3.1.1 Up until the point at which my heart stops, I wish that all other treatment and interventions be done as medically indicated to prevent my heart from stopping (unless I have indicated otherwise below).

2.3.1.2 By initialing below, I hereby request that my Agent and physician do the following:

2.3.1.2.1 Enter a Do Not Resuscitate order into facility medical records (if applicable).

2.3.1.2.2 Create and sign a Durable Do Not Resuscitate (DDNR), Emergency Medical Services Do Not Resuscitate (EMSDNR), or other order of substantially similar nature (that shall hopefully be recognized by pre-hospital medical providers) pursuant to current state laws. I request that my Agent place a copy of said instrument in an obvious place for medical providers to locate (such as on my refrigerator, or on the door to my room).

2.3.2 If I have placed my initials next to a **DNI (Do Not Intubate)** option below, it is my intention that I shall not be intubated to assist with my ventilation under any circumstances, whether or not my heart or breathing has stopped. Intubation as said in this paragraph shall include endotracheal intubation and the placement of supraglottic airways. It is my intention that a DNI order shall not in any way be construed as a DNR, however shall be made to specifically limit the aforesaid interventions. Furthermore, it is my intention that the below interventions shall be performed as medically indicated, and that a DNI order shall have no bearing over the following interventions:

2.3.2.1 CPAP (with face mask, not via Endotracheal nor Supraglottic Airway).

2.3.2.2 BiPAP (with face mask, not via Endotracheal nor Supraglottic Airway).

2.3.2.3 Insertion of NPAs (Nasal Pharyngeal Airways).

2.3.2.4 Insertion of OPAs (Oral Pharyngeal Airways).

2.3.2.5 Assisted Ventilations with Bag-Valve-Mask device (with face mask, not via Endotracheal nor Supraglottic Airway).

DRAFT

2.3.3 If I have placed my initials next to a **DNH (Do Not Hospitalize**) option below, it is my intention that I shall not be transported to an emergency room nor other hospital facility (nor any other facility with a substantially similar level of care as a hospital) for my medical needs, under any circumstances.

2.3.3.1 This shall include transportation by ambulance (both Emergency 911 or Private) or any other means of public or private transportation.

2.3.3.2 It is not my intention that this DNH order will limit in any way the scope of medical treatment that I may receive at my current location; however, this DNH shall specifically prevent my transportation to the aforesaid facilities.

2.3.4 **If I <u>Do</u> <u>Not</u> Require the Nursing Home Level of Care,** but I do require a lower level of long-term care, such as assisted living at home or in an assisted living facility, then I request that my Agent and my physician enter or do not enter in my medical records the following orders ***(initial one option on each row)***:

_____Enter a DNR _____**Don't** Enter a DNR ____May Enter DNR at Agent Discretion

_____Enter a DNI _____**Don't** Enter a DNI ____May Enter DNI at Agent Discretion

_____Enter a DNH _____**Don't** Enter a DNH ____May Enter DNH at Agent Discretion

2.3.5 **If I <u>Do</u> Require the Nursing Home Level of Care,** I request that my Agent and my physician enter or do not enter in my medical records the following orders ***(initial one option on each row)***:

_____Enter a DNR _____**Don't** Enter a DNR ____May Enter DNR at Agent Discretion

_____Enter a DNI _____**Don't** Enter a DNI ____May Enter DNI at Agent Discretion

_____Enter a DNH _____**Don't** Enter a DNH ____May Enter DNH at Agent Discretion

THE REMAINDER OF THIS PAGE IS INTENTIONALLY BLANK

DRAFT

PART 3 NEAR-DEATH DIRECTIVE

3.1 IF MY CONDITION IS TERMINAL:

3.1.1 If at any time I am suffering from a terminal condition (as defined in Section 5.11 of this instrument) and the only thing holding me to this life is (or would be) the application of life-prolonging procedures (as defined in Section 5.6 of this instrument) that serve only to artificially prolong the dying process, then in the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this statement be honored by my family, physicians, and health care providers as the final expression of my legal right to direct my own end-of-life decision-making and my acceptance of the consequences of such direction.

3.1.2 ***Unless I have initialed an Alternate End-of-Life Wish below, my end-of-life wishes are as follows***:

3.1.2.1 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 and health care providers to discontinue further life-prolonging procedures, permitting me to die naturally, with the exception only of any procedure and/or medication necessary to provide me with comfort care or to alleviate pain; and

3.1.2.2 I want appropriate medication, health care procedures, and alternative health care 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 health care procedures would shorten my remaining life;

3.1.2.3 If I have a pacemaker or an implantable cardioverter defibrillator (ICD) and/or other implanted device designed to keep me alive, and have been determined to have a terminal condition, I wish all such electrical devices be turned off as soon as possible, and

3.1.2.4 I direct that my Agent and my physician place in my medical records any type of DNR Order as defined in Section 2.3 above.

DRAFT

3.2 **ALTERNATE END-OF-LIFE WISHES.** If I am suffering from a terminal condition, I direct that the actions taken by my Agent, family, physicians, health care providers, and all those concerned with my care be controlled by the following declaration that I have initialed ***(initial only one)***:

_____ If my condition is terminal, I want all available health care treatment. No matter what my condition is, I want to be given all available health care treatment in accordance with accepted health care standards. Evaluation of my future "quality of life" is not to be a factor *(if you initial this option, please also initial one of the below):*

_____ I **DO** want medication or health care procedures to relieve pain and suffering, understanding that such medication or health care procedures may shorten my remaining life.

_____ I **DO NOT** want medication or health care procedures to relieve pain and suffering, if such medication or health care procedures have the potential to shorten my remaining life.

_____ If my condition is terminal, I want to be permitted to die naturally, and I do not want **ANY** life-prolonging procedures. If life-prolonging procedures are started, I want them stopped, with the exception only of any procedure necessary to provide me with comfort care or to alleviate pain.

_____ If my condition is terminal, I **DO NOT** want the **specific life-prolonging procedures** that I have initialed below to be performed, under any circumstances; however, any and all other life-prolonging procedures or health care treatment may be performed at the discretion of my Agent *(if you initial this option, please also initial at least one of the following below unwanted procedures)*:

_____ if my condition is terminal, I do not want surgery;

_____ if my condition is terminal, I do not want medications (including any and all prescription and nonprescription drugs, medications, vitamins, minerals, dietary supplements, and antibiotics);

_____ if my condition is terminal, I do not want cardiopulmonary resuscitation, artificial respiratory and circulatory aids such as respirators, ventilators, or the administration of oxygen;

_____ if my condition is terminal, I do not want blood, plasma, or platelet transfusions;

_____ if my condition is terminal, I do not want chemotherapy, radiation, or other cancer treatments;

_____ if my condition is terminal, I do not want kidney dialysis;

_____ if my condition is terminal, I do not want artificially administered hydration and nutrition (*i.e.*, feeding through a gastric or nasogastric tube);

_____ if my condition is terminal, I do not want spoon-feeding or other manual feeding of me by another person when I have advanced dementia, if allowed by state law.

DRAFT

PART 4 AFTER- DEATH DIRECTIVE

4.1 AFTER MY DEATH. I direct that my Agent and my family, physicians, and all those concerned be guided by the following declaration: ***Unless I have initialed one or more Alternate Wishes below, I authorize my Agent to make all decisions with regard to my remains, as my Agent deems appropriate under the circumstances.***

4.2 ALTERNATE ORGAN DONATION WISHES *(initial only one)*:

_____I do **not** wish to donate any of my organs or tissues for any purposes.

_____I do wish to donate my organs or tissues for the purposes indicated below. I understand that if my organs are able to be removed for donation, I will need to be kept on life-sustaining treatment temporarily until the procedure is complete, *regardless* of whether I have stated earlier in this document that I would not want life-sustaining treatment *(initial all that apply):*

____ If any of my tissue or organs would be of value, I direct that an anatomical gift may be made of all of my body or certain organs or tissues for (*initial all that apply*):

_____Transplant _____Therapy _____Health care/educational use

_____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: _____

_____If I'm a match, I wish to donate _____ to _____

4.3 ALTERNATE AUTOPSY WISHES *(initial only one)*:

_____ I request an autopsy so my family will be assured of the cause of my death.
_____ I do not want an autopsy under any circumstances, unless required under existing law.

4.4 COLLECTION AND RELEASE OF DNA *(initial only one)*:

_____ I request that my DNA be collected, and submitted to genealogy and/or ancestry databases in my Agent's discretion.

_____ At no time, except in accordance with a duly executed search warrant or court order, shall my Agent authorize the collection, testing, or release of my DNA information to law enforcement, nor to any other public or private entities (*e.g.*, heritage, medical testing, etc.).

DRAFT

4.5 PUBLICATION OF DEATH NOTICE / OBITUARY *(initial only one)*:

_____ I wish for a death notice and obituary to be published in an appropriate local newspaper

_____ I do not wish for any type of death notice or obituary to be published in any newspaper or online.

Please provide, in a separate attachment, any special language or facts that you would like mentioned in your obituary.

4.6 HOW WOULD YOU LIKE TO BE REMEMBERED?

Please provide, in a separate attachment, any special language or facts that you would like mentioned in your biography for your Memorial Service.

4.7 FINAL DISPOSITION OF REMAINS:

____ I would like to be buried ☐ No specific location ☐ Location: _____

____ I would like to be cremated ☐ No specific instructions ☐ Ashes given to _____

☐ Ashes scattered at _____ ☐ Ashes interred at _____

____ I have signed a contract with _____ *(name of Funeral Home)* in _____ *(location of Funeral Home)* with respect to disposition of my remains.

____ I own (or have the right to have my remains interred in) the grave or repository designated: _____ *(plot or niche number)* at _____ *(facility name)* located in _____, and I wish to have my remains placed there

____ I would like following name on my grave marker: _____

____ I would like the following epitaph (inscription on my grave marker or headstone): _____

_____

4.8 CEREMONIAL ARRANGEMENTS:

_____ Funeral service. *Comments:* _____

☐ Open casket if appropriate ☐ Closed casket ☐ Agent's decision

_____ Memorial service. *Comments:* _____

_____ Graveside service. *Comments:* _____

_____ Religious service(s). *Comments:* _____

_____ No ceremony or service.

DRAFT

4.9 LOCATION(S) AND SIZE OF SERVICE(S):

_____ Specific place of worship: _____

_____ The place of worship where I am a member at the time of my death, or that I regularly attended prior to my death.

_____ Any place of worship of the following denomination: _____.

_____ Funeral home or cemetery chapel: _____.

_____ Graveside.

_____ Size of service: ☐ Open to all ☐ Family only ☐ No service

THE REMAINDER OF THIS PAGE IS INTENTIONALLY BLANK

DRAFT

SIGNATURE. By signing below on this day, August 1, 2022, I indicate that I am emotionally and mentally capable of making this Advance Directive. I understand the purpose and effect of this instrument. I understand that I may revoke all or any part of the instrument at any time (1) with a signed and dated written revocation; or (2) by physically destroying or cancelling this Advance Directive myself, or directing someone else to destroy it in my presence; or (3) by my oral expression or intent to revoke it. From time to time I may alter this instrument to update the addresses and/or telephone numbers of my Agents set forth in Section 1, and such alternations shall not in any way affect the validity of this instrument. Photocopies or facsimiles of this instrument shall have the same force and effect as the original; and any person, firm, institution, corporation, or other entity may rely on this writing until receipt of actual knowledge that I have revoked it. The authorization given pursuant to this instrument shall not terminate in the event I am incapable of making an informed decision.

_____
Adam Testcase

WITNESS:

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

_____
Witness Testcase
10640 Main Street, Suite 200
Fairfax, VA 22030

_____
Witness Testcase
10640 Main Street, Suite 200
Fairfax, VA 22030

COMMONWEALTH OF TESTCASE
CITY OF FAIRFAX

SUBSCRIBED, SWORN TO, AND ACKNOWLEDGED before me by the said Adam Testcase, and acknowledged before me by the said Witness Testcase and Witness Testcase, as witnesses, on this day, August 1, 2022.

_____
Notary Testcase, Notary Public
My commission expires: January 1, 2222

DRAFT

PART 5 DEFINITIONS

5.1 "Agent" means the then-serving individual or individuals whom I have named in Part 1 of this instrument. My Agent may also be referred to as my Medical Attorney-in-Fact or Health Care Agent.

5.2 "Attending physician" means the physician who has primary responsibility for my treatment and care.

5.3 "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/or complete physical dependency; and (2) for which, to a reasonable degree of medical probability, treatment of the irreversible condition would be medically ineffective.

5.4 "Health care" means the furnishing of services to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability, including but not limited to, medications; surgery; blood transfusions; chemotherapy and other cancer treatments; radiation therapy; admission to a hospital, assisted living facility, or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

5.4.1 "Alternative health care" includes alternative or holistic health care services such as acupressure, acupuncture, aromatherapy, ayurvedic medicine, chiropractic, chromotherapy, colon therapy, craniosacral therapy, diet therapy, flower essences, herbal therapy, homeopathy, hydropathy, hypnotherapy, kinesiology, magnet therapy, massage, meditation, naturopathy, and reiki.

5.5 "Incapable of making an informed decision" means unable to understand the nature, extent, or probable consequences of a proposed health care decision, or unable to make a rational evaluation of the risks and benefits of the proposed health care 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 my attending physician and a second physician or licensed clinical psychologist after a personal examination of me, and shall be certified in writing. The second physician or licensed clinical psychologist shall not be otherwise currently involved in my treatment, unless such independent physician or licensed clinical psychologist is not reasonably available. Such certification shall be required before health care is provided, continued, withheld, or withdrawn; before any named Agent shall be granted authority to make health care decisions on my behalf; and before, or as soon as reasonably practicable after, health care is provided, continued, withheld, or withdrawn; such certification must also be recertified every one hundred eighty (180) days while the need for health care continues and every 180 days thereafter; however, I may request more frequent recertifications, but no more frequently than every sixty (60) days.

DRAFT

5.6 "Life-prolonging procedure" means any medical procedure, treatment, or intervention which if you are already in a terminal condition, mechanically or artificially supports what is usually a spontaneous vital function; and when provided to a patient in a terminal condition serves only to prolong the dying process.

"Life-prolonging procedures" do not include the administration of medications 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.

5.7 "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 (assisted by voluntary or employed help), adult day care, or care in assisted living facilities or nursing homes or other health care facilities.

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

5.9 "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 the eyes may be open, but the person cannot think or respond.

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

5.11 "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.