

ADVANCE MEDICAL DIRECTIVE

I, Rockford Laydeesman, willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows:

I understand that my advance directive may include the selection of an agent as well as set forth my choices regarding health care. The term "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, chemotherapy; including but not limited to, medications; surgery; blood transfusions; radiation therapy; admission to a hospital, nursing home, assisted living facility, or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase "incapable of making an informed decision" means unable to understand the nature, extent, and probable consequences of a proposed health care decision or unable to make a rational evaluation of the risks and benefits of a 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 capacity reviewer, if certification by a capacity reviewer is required by law, after a personal examination of me and shall be certified in writing. Such certification shall be required before health care is provided, continued, withheld, or withdrawn, before any named agent shall be granted authority to make health care decisions on my behalf, and before, or as soon as reasonably practicable after, health care is provided, continued, withheld, or withdrawn and every 90 days thereafter while the need for health care continues.

If, at any time, 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of receiving such notice, that such determination has been made before health care is provided, continued, withheld, or withdrawn. Such notice shall also be provided, as soon as practical, to my named agent or person authorized pursuant to § 54.1-2986 of the Code of Virginia to make health care decisions on my behalf. If I am later determined to be capable of making an informed decision by a physician, in writing, upon personal examination, any further health care decisions will require my informed consent.

OPTION I: APPOINTMENT OF AGENT

I hereby appoint my son, Rockford Laydeesman Jr, of 123 Street, Alexandria, Virginia, 22310, 703-360-8245, as my agent to make health care decisions on my behalf as authorized in this document. If Rockford Laydeesman Jr is not reasonably available or is unable or unwilling to

act as my agent, then I appoint my daughter, Delilah Laydeesman, of 456 Street, Alexandria, Virginia, 22308, 703-998-1647, 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.

OPTION II: 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 authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days, ~~even over my protest~~, if 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. If my physician or licensed clinical psychologist hereby attests that I am capable of making an informed decision and that I understand the consequences of this provision of my advance directive, I grant my agent the ability to make any decision based on my best interest;

G. ~~To authorize the specific types of health care identified in this advance directive even over my protest;~~

H. 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;

I. ~~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;~~

J. ~~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;~~

K. To make decisions regarding visitation during any time that I am admitted to any health care facility;

L. 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.

OPTION III: 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;~~

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);~~

OPTION IV: END OF LIFE INSTRUCTIONS

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 direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

~~OPTION: LIFE-PROLONGING PROCEDURES DURING PREGNANCY.~~

~~If I am pregnant when my attending physician determines that I have a terminal condition, my decision concerning life-prolonging procedures shall be modified as follows:~~

OPTION: OTHER DIRECTIONS ABOUT LIFE-PROLONGING PROCEDURES.

OPTION: ~~My other instructions regarding my care if I have a terminal condition are as follows:~~

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this advance directive shall be honored by my family and physician as the final expression of my legal right to refuse health care and acceptance of the consequences of such refusal.

OPTION V: APPOINTMENT OF AN AGENT TO MAKE AN ANATOMICAL GIFT OR ORGAN, TISSUE, OR EYE DONATION

~~Upon my death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations may be made pursuant to Article 2 (§ 32.1-289.2 et seq.) of Chapter 8 of Title 32.1.~~

This advance directive shall not terminate in the event of my disability.

AFFIRMATION AND RIGHT TO REVOKE:

By signing below, I indicate that I am emotionally and mentally capable of making this advance 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 if I am of capacity and with a signed and dated notarized document expressing as such.

Rockford Laydeesman

Date: January 12, 2020

Signature of Declarant

The declarant signed the foregoing advance directive in my presence.

Witness: Sophia Jones

Date: January 12, 2020

Witness Name Printed: Sophia Jones

Witness: Paula Jimmy

Date: January 12, 2020

Witness Name Printed: Paula Jimmy

