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Department of Veterans Affairs

VA ADVANCE DIRECTIVE
DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL

INSTRUCTIONS

This advance directive form is an official document where you can write down your preferences for your health care. If someday you can't make health care decisions for yourself anymore, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, mental health care, long-term care, or other types of health care

You may complete some, none, or all sections of this form. If you need more space for any part of the form, you may attach extra pages. Be sure to initial and date every page that you attach. You also must initial the sections you complete and sign the form. If you are unable to initial or sign the form because of a physical impairment, you can place an "X", thumbprint, or stamp on the form instead of your initials and signature. If a physical impairment prevents you from doing any of these things, you can ask someone else who is with you to sign, place an "X", thumbprint, or stamp on the form.

When you complete this form, it's important that you also talk to a member of your health care team, family, and other loved ones to explain what you meant when you filled out the form. A member of your health care team can help you with this form and can answer any questions that you have.

PART I: PERSONAL INFORMATION

NAME *(Last, First, Middle):*	DATE OF BIRTH *(mm/dd/yyyy)*:

STREET ADDRESS:

CITY, STATE, ZIP:

HOME PHONE WITH AREA CODE:	WORK PHONE WITH AREA CODE:	MOBILE PHONE WITH AREA CODE:

PUBLIC BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0556, and it expires 04/30/2024. Public reporting burden for this collection of information is estimated to average 30 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0556 in any correspondence. Do not send your completed VA Form 10-0137 to this email address.

PRIVACY ACT STATEMENT: The information requested on this form is solicited under the authority of 38 C.F.R. §17.32. It is being collected to document your preferences for your health care in the event that you cannot speak for yourself anymore. The information you provide may be disclosed outside the VA as permitted by law. Possible disclosures include those that are described in the "routine uses" identified in the VA system of records 24VA10P2, Patient Medical Records-VA, published in the Federal Register in accordance with the Privacy Act of 1974. This is also available in the Compilation of Privacy Act Issuances. You may choose to fill out this form or not, but without this information, VA health care providers may not clearly understand your preferences. If you do not fill out this form, there will be no effect on any benefits you are entitled to receive.

NAME *(Last, First, Middle):*	DATE OF BIRTH *(mm/dd/yyyy)*:

PART II: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. It lets you appoint a specific person to make health care decisions for you in case you can't make decisions for yourself anymore. This person will be called your Health Care Agent.

Your Health Care Agent should be someone:

- You trust
- Who knows you well
- Who is familiar with your values and beliefs

If you get too sick to make decisions for yourself, your Health Care Agent will have the authority to make all health care decisions for you. This includes decisions to admit and discharge you from any hospital or other health care institution. Your Health Care Agent can also decide to start or stop any type of health care treatment. He or she can access your personal health information, and medical records, including information about whether you have been tested for HIV or treated for AIDS, sickle cell anemia, substance abuse or alcoholism.

NOTE: If you wish to give general permission for VA to share your medical records or health information with others, you can complete VA Form 10-5345 (Request for and Authorization to Release Medical Records or Health Information). You can get VA Form 10-5345 from your VA health care provider or you can get it using a computer from this website http://www4.va.gov/vaforms/medical/pdf/vha-10-5345-fill.pdf.

A - HEALTH CARE AGENT

Place your initials in the box next to your choice. Choose only one.

Initials	
Initials	I don't wish to appoint a Health Care Agent right now. (Skip this section and go to Part III, Living Will.)
Initials	I appoint the person named below to make decisions about my health care if I can't decide for myself anymore.

Name *(Last, First, Middle):*	Relationship to Me:
Street Address:	
City, State, Zip:	

Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

B - ALTERNATE HEALTH CARE AGENT

Fill out this section if you want to appoint a second person to make health care decisions for you, in case the first person isn't available.

Initials	
Initials	If the person named above can't or doesn't want to make decisions for me, I appoint the person named below to act as my Health Care Agent.

Name *(Last, First, Middle):*	Relationship to Me:
Street Address:	
City, State, Zip:	

Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

NAME *(Last, First, Middle):*	DATE OF BIRTH *(mm/dd/yyyy)*:

PART III: LIVING WILL

This section of the advance directive form is called a Living Will. This section of it lets you write down how you want to be treated in case you aren't able to decide for yourself anymore. Its purpose is to help others decide about your care.

A - SPECIFIC PREFERENCES ABOUT LIFE-SUSTAINING TREATMENTS

In this section, you can indicate your preferences for life-sustaining treatments in certain situations. Some examples of life-sustaining treatments are:

- CPR (cardiopulmonary resuscitation)
- a breathing machine (mechanical ventilation)
- kidney dialysis
- a feeding tube (artificial nutrition and hydration)

Think about each situation described on the left and ask yourself, “In that situation, would I want to have life-sustaining treatments?” Place your initials in the box that best describes your treatment preference. You may complete some, all, or none of this section. Choose only one box for each statement.

	Yes. I would want life-sustaining treatments.	I'm not sure. It would depend on the circumstances.	**No.** I would not want life-sustaining treatments.
If I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery.	Initials	Initials	Initials
If I have permanent, severe brain damage that makes me unable to recognize my family or friends (for example, severe dementia).	Initials	Initials	Initials
If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting).	Initials	Initials	Initials
If I need to use a breathing machine and be in bed for the rest of my life.	Initials	Initials	Initials
If I have pain or other severe symptoms that cause suffering and can't be relieved.	Initials	Initials	Initials
If I have a condition that will make me die very soon, even with life-sustaining treatments.	Initials	Initials	Initials
Other:	Initials	Initials	Initials

NAME *(Last, First, Middle):*	DATE OF BIRTH *(mm/dd/yyyy)*:

B - MENTAL HEALTH PREFERENCES

This section is optional. You may skip this section if you do not have a serious mental health problem or if you do not want to write down your preferences for mental health care. If you have a serious mental health condition, you might want to write down medications that have worked for you in the past and that you would want again, or you might want to write down the mental health facilities or hospitals that you like and those that you don't like. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

C - ADDITIONAL PREFERENCES

This section is optional. In this space, you can write other important preferences for your health care that aren't described somewhere else in this document. For example, these might be social, cultural, or faith-based preferences for care, or preferences about treatments such as feeding tubes, blood transfusions, or pain medications. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

NAME *(Last, First, Middle):*	DATE OF BIRTH *(mm/dd/yyyy)*:

D - HOW STRICTLY YOU WANT YOUR PREFERENCES FOLLOWED

Place your initials in the box next to the statement that reflects how strictly you want others to follow your preferences. Choose only one.

Initials	I want my preferences, as expressed in this Living Will, to serve as a general guide. I understand that in some situations, the person making decisions for me may decide something different from the preferences I express above, if they think it's in my best interests.
Initials	I want my preferences, as expressed in this Living Will, to be followed strictly, even if the person making decisions for me thinks that this isn't in my best interests.

PART IV: SIGNATURES

A - YOUR SIGNATURE

By my signature below, I certify that this form accurately describes my preferences.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

B - WITNESSES' SIGNATURES

Two people must witness your signature. Witnesses to the patient's signing of an advance directive are attesting by their signatures only to the fact that they saw the patient or designated third party sign the VA Advance Directive form. Neither witness may, to the witness' knowledge, be named as a beneficiary in the patient's estate, appointed as health care agent in the advance directive, or financially responsible for the patient's care. Nor may a witness be the designated third party who has signed the VA Advance Directive form at the direction of the patient and in the patient's presence.

Witness #1

I personally witnessed the signing of this advance directive. I am not the designated third party who signed this VA Advance Directive form at the direction of the patient and in the patient's presence. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the patient making this advance directive. To the best of my knowledge, I am not named as a beneficiary in the patient’s estate.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

Name *(Printed or Typed):*

Street Address:

City, State, Zip:

Witness #2

I personally witnessed the signing of this advance directive. I am not the designated third party who signed this VA Advance Directive form at the direction of the patient and in the patient's presence. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the patient making this advance directive. To the best of my knowledge, I am not named as a beneficiary in the patient’s estate.

SIGNATURE *(Sign in ink)*:	DATE *(mm/dd/yyyy)*:

Name *(Printed or Typed):*

Street Address:

City, State, Zip:

NAME *(Last, First, Middle):*	DATE OF BIRTH *(mm/dd/yyyy)*:

PART V: SIGNATURE AND SEAL OF NOTARY PUBLIC *(Optional)*

This VA Advance Directive form is valid in VA facilities without being notarized. However, you may need to have it notarized to be legally binding outside the VA health care setting. Space for a Notary's signature and seal is included below.

On this _____ day of _____ , in the year of _____ , personally appeared before me

_____,

known by me to be the person who completed this document and acknowledged it as their free act and deed.

IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____,

State of _____ , on the date written above.

Notary Public: _____ Commission Expires: _____

[SEAL]