

**ADVANCE DIRECTIVE  
OF  
SALLY ANN CLIENT**

COMMONWEALTH OF VIRGINIA  
CITY OF ROANOKE, to-wit:

DECLARATION UNDER THE HEALTH CARE DECISIONS ACT

I, Sally Ann Client, willfully and voluntarily make this advance directive under the Health Care Decisions Act under the Code of Virginia, 1950, as amended (the "Act"). All terms in **bold** shall have the meanings given under the Act, including any amendments after the signing of this advance directive.

**I. DIRECTIONS REGARDING LIFE-PROLONGING PROCEDURES**

If at any time I am **incapable of making an informed decision** and my attending physician determines that I have a **terminal condition** where the application of **life-prolonging procedures** would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of medical procedures deemed necessary to provide me with comfort care or to alleviate pain.

If at any time I am **incapable of making an informed decision** and my attending physician determines that I have advanced dementia or other cognitive deficit that leaves me unaware of myself or my surrounding, unable to interact with others, and/or unable to recognize consistently my loved ones and it is reasonably certain I will never recover this awareness or ability even with medical treatment, I direct that **life-prolonging procedures** be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of medical procedures deemed necessary to provide me with comfort care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that my family, my agent (identified and authorized below), and my physician honor this declaration as the final expression of my legal right to refuse medical or surgical treatment and my acceptance of the consequences of such refusal.

**II. AGENT FOR MAKING HEALTH CARE DECISIONS**

I appoint my son Tucker Oliver Client as my primary agent to make health care decisions on my behalf as authorized in this advance directive. If my primary agent is **incapable of making an informed decision**, unable or unwilling to act as my agent, or is not reasonably available to act, then I appoint my daughter Barbara Lynn Client as my successor agent to make health care decisions on my behalf as authorized in this advance directive. I have listed each of my agents' current contact information on the attached Schedule A, which may be amended by me from time to time.

### III. AUTHORITY GRANTED TO MY AGENT

I grant to my agent full power and authority to make health care decisions on my behalf, as described below, whenever I have been determined **incapable of making an informed decision** about providing, withholding, or withdrawing medical treatment. 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 advance directive 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 that my agent knows, or ought to know upon reasonable inquiry, is contrary to my religious beliefs or basic values, whether expressed orally or in writing. If my agent cannot determine what treatment choice I would have made on my own behalf, then my agent shall choose for me based on what my agent believes to be in my best interests.

In addition to all powers granted to my agent under applicable law, my agent shall have these powers:

- A. To consent to or refuse or withdraw consent to any type of medical 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 standard dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or inadvertently hastens 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, as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Regulations issued thereunder, 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, adult home, or other medical care facility;
- E. To authorize my admission to a health care facility for the treatment of mental illness for the maximum time permitted under applicable law (currently 10 days), 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, that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility;
- F. To continue to serve as my agent even in the event that I protest the agent's authority;
  - G. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law that offers the prospect of direct therapeutic benefit to me;
  - H. To authorize my participation in any health care study approved by an institutional review board or research review committee pursuant to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though it offers no prospect of direct benefit to me;
  - I. To make decisions regarding visitation during any time that I am admitted to any health care facility;
  - J. To authorize and/or consent to the entry of a **Durable Do Not Resuscitate (DDNR)**, as permitted under the Act;
  - K. To make all health care decisions authorized in the prior paragraphs even if I object, to the extent permitted by law; and
  - L. To take any lawful actions necessary to carry out these decisions, including granting releases of liability to medical providers.

#### **IV. ADMINISTRATIVE PROVISIONS**

My agent is not liable for the costs of treatment given pursuant to my agent's authorization, based solely on that authorization. My agent shall not be entitled to compensation for serving as my agent under this advance directive, but my agent shall be entitled to reimbursement for all reasonable costs and expenses, including reasonable attorney's fees, actually incurred and paid by my agent on my behalf while acting under this advance directive as my agent.

This advance directive does not terminate in the event of my disability and expires only in the event that I revoke it as provided below. This advance directive shall be governed by the laws of the Commonwealth of Virginia. It is my intent that this advance directive be honored in any jurisdiction where it may be presented and for any such jurisdiction to refer to Virginia law to interpret and determine the validity of this advance directive.

I understand that Virginia has created a free online advance directive registry at Connect Virginia (connectvirginia/org/adr) that allows Virginia residents to securely store important healthcare documents so that family members, medical providers, emergency personnel, or other persons may know my wishes, but that it remains my responsibility to provide copies of this advance directive to my health care providers and agents and to make them aware of my decision, if made, to upload this advance directive to the online registry.

**V. SIGNATURES AND REVOCATION PROVISIONS**

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 advance directive. I understand I may revoke all or any part of this advance directive at any time (i) with a signed, dated writing; (ii) by physical cancellation or destruction of this advance directive by myself or by someone else who I direct to destroy it in my presence; or (iii) by my oral expression, in a clear and consistent manner to my attending physician, of my intent to revoke all or any part of this advance directive, provided that for any of these methods I am at such time capable of understanding the nature and consequences of my revocation.

Date: October 29, 2024

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Sally Ann Client

The Declarant, Sally Ann Client, is known to me and is capable of making an informed decision about health care at this time. The Declarant signed this advance directive in my presence.

WITNESS:

WITNESS:

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On October 29, 2024 personally appeared before me, a notary public within and for the aforesaid jurisdiction, Sally Ann Client, the Declarant, and Carter R. Brothers and Nathan A. Kottkamp, Witnesses, whereupon the Declarant acknowledged the Declarant freely and voluntarily executed the foregoing for the purposes stated therein, and the Witnesses acknowledged that they witnessed the Declarant's execution of the foregoing and that they then executed the same as Witnesses.

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Notary Public

My commission expires:

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SCHEDULE A

Contact Information for Tucker Oliver Client:

Address: 8 Revelo Plantation Lane  
Memphis, TN 37501

Telephone: (555) 615-0001

Email: Bigtuck@gmail.com

Contact Information for Barbara Lynn Client:

Address: 1008 Iroquois Lane  
Nashville, TN 37215

Telephone: (555) 615-0002

Email: Barbaralynn1958@yahoo.com