WORLD HELP, INC. ADVANCE MEDICAL DIRECTIVE FOR TRAVEL

Note to Signer: Traveling in Third World countries presents higher-than-normal risks of illness and injury. To ensure that, if during the Trip you are unable to make health care decisions for yourself, someone else is properly authorized to do so, we ask you to provide us with an advance health care directive. You may give us a copy of a health care directive you have already signed, or you may complete this directive and provide it to us.

This advance medical directive is based on a form widely used and recognized in Virginia. It enables you to appoint a family member, trusted friend, or other person (including a World Help employee traveling with you) to make health care decisions for you, but only if you are unable to make such decisions for yourself. This directive is expressly effective only during the Trip, and does not authorize the individual(s) appointed to act for you at any other time, or with respect to any matters other than health care decisions.

I, _____, am executing this Advance Medical Directive at the request of World Help, Inc. in connection with my participating in a trip sponsored by World Help to _____, beginning on _____, 20___, and ending on _____, 20___("the Trip"). I intentionally 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 includes the selection of an agent in addition to setting 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, including but not limited to medications; surgery; blood transfusions; chemotherapy; 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; 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.

This advance directive shall not terminate in the event of my disability, but shall terminate upon my return to the United States at the end of the Trip.

SECTION I: APPOINTMENT OF AGENT

I hereby appoint the following as my primary agent to make health care decisions during the Trip on my behalf as authorized in this document:

Name of Primary Agent Telephone Fax if any

_____Address

E-mail if any

If the above-named primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as successor agent:

Name of Successor Agent Telephone Fax if any

_____Address

E-mail if any

If neither of the two individuals named above is reasonably available, or is unable or unwilling to act as my agent, then I appoint as my agent the employee of World Help named for this purpose by World Help, as evidenced by a writing signed by any officer of World Help.

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 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 non-treatment. My agent shall not make any decision regarding my health care which he or she 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 or she believes to be in my best interests.

My agent shall not be liable for the costs of health care that he or she authorizes, based solely on that authorization.

SECTION 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 oral or written information 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 in Subsections E and/or F below.

E. To continue to serve as my agent even if I protest the agent's authority after I have been determined to be incapable of making an informed decision.

F. To make decisions regarding visitation during any time that I am admitted to any health care facility, provided that my agent shall not prevent members of my immediate family from visiting, unless they are disruptive, their visit is likely to be detrimental to my health, or they are excluded by the health care facility.

G. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

(You must sign below in the presence of two witnesses.)

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I state 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 that I may revoke all or any part of this document at any time (i) with a signed, dated writing; (ii) by physical cancellation or destruction of this advance directive by myself or by directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke. A photocopy of this Advance Medical Directive shall be valid as if signed by me and my witnesses.

Signature of Declarant Date

The Declarant signed the foregoing advance directive in my presence.

(Witness) (Witness)