Print Form

Opt In ☐ **INITIAL box if you agree to have this advance directive submitted to the WV *e-Directive* Registry, and released to treating health care providers. Complete information to RIGHT.**

REGISTRY FAX: 304-293-7442

Last Name/First/Middle _____
Address _____
City/State/Zip _____
Date of Birth (mm/dd/yyyy) _____/_____/_____
Last 4 SSN ___ ___ ___ ___ **Gender M**___ **F**___

STATE OF WEST VIRGINIA
COMBINED
MEDICAL POWER OF ATTORNEY
AND LIVING WILL

The Person I Want to Make Health Care Decisions
For Me When I Can't Make Them for Myself
And
The Kind of Medical Treatment I Want and Don't Want
If I Have a Terminal Condition or Am In a Persistent Vegetative State

Dated: _____ , 20 ____

I, _____ , hereby

_____

(*Insert your name and address*)

appoint as my representative to act on my behalf to give, withhold or withdraw informed consent to health care decisions in the event that I am not able to do so myself

The person I choose as my representative is:

_____

_____

(*Insert the name, address, area code and telephone number of the person you wish to designate as your representative*)

The person I choose as my successor representative is:

If my representative is unable, unwilling or disqualified to serve, then I appoint

_____

_____

(Insert the name, address, area code and telephone number of the person you wish to designate as your successor representative)

This appointment shall extend to, but not be limited to, health care decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home health care. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, or autopsy if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment or procedures. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions.

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated below.

I am giving the following SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments).

1. If I am very sick and not able to communicate my wishes for myself and I am certified by one physician who has personally examined me, to have a terminal condition or to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others,) I direct that life-prolonging medical intervention that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain.

2. Other directives:

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

_____ DATE _____
Signature of the Principal

I did not sign the principal's signature above. I am at least eighteen years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, or legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

Witness _____ DATE _____

Witness _____ DATE _____

STATE OF _____

COUNTY OF _____

I, _____, a Notary Public of said County, do certify that_____, as principal, and _____ and _____, as witnesses, whose names are signed to the writing above bearing date on the _____ day of _____, 20___, have this day acknowledged the same before me.

Given under my hand this _____ day of _____, 20___.

My commission expires:_____

_____
Signature of Notary Public