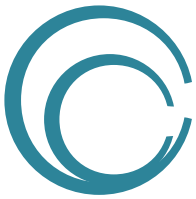

compassion & choices

Care & Choices at the End of Life.

Advance Directive

Planning for Important Healthcare Decisions

West Virginia

West Virginia Medical Power of Attorney

THE PERSON I WANT TO MAKE HEAL THCARE DECISIONS FOR ME WHEN I CAN'T MAKE THEM FOR MYSELF

Dated: _____, 20 _____.
(day, month) (year)

I, _____

_____,
(insert your name and address)

hereby appoint as my representative to act on my behalf to give, withhold or withdraw informed consent to healthcare 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, and telephone number of the person you wish to designate as your successor representative)

This appointment shall extend to, but not be limited to, healthcare decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home healthcare. 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.

(Continued)

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the healthcare 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 interests 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 healthcare 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 healthcare 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, 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)

(Continued)

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

X _____
(signature of 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: _____

_____
(notary public)

P. O. Box 101810
Denver, CO 80250

tel 800.247.7421
fax 866.312.2690

West Virginia Living Will

THE KIND OF MEDICAL TREATMENT I WANT AND DON'T WANT IF I HAVE A TERMINAL CONDITION OR AM IN A PERSISTENT VEGETATIVE STATE

Living will made this _____ (day) day of _____ (month), _____ (year).

I, _____ (print name),

being of sound mind, willfully and voluntarily declare that I want my wishes to be respected if I am very sick and not able to communicate my wishes for myself. In the absence of my ability to give directions regarding the use of life-prolonging medical intervention, it is my desire that my dying shall not be prolonged under the following circumstances:

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.

I give the following SPECIAL DIRECTIVES OR LIMITATIONS: (Comments about tube feedings, breathing machines, cardipulmonary resuscitation, dialysis and mental health treatment may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.)

It is my intention that this living will be honored as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences resulting from such refusal. I understand the full import of this living will.

(Continued)

Signed _____

Address _____

I did not sign the principal's signature above for or at the direction of the principal. I am at least eighteen years of age and am not related to the principal by blood or marriage, entitled to any portion of the estate of the principal to the best of my knowledge under any will of principal or codicil thereto, or directly financially responsible for principal's medical care. I am not the principal's attending physician or the principal's medical power of attorney representative or successor medical power of attorney representative under a medical power of attorney.

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: _____

_____
(notary public)

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