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Legal Forms & Services

FirstName LastName

WEST VIRGINIA HEALTH CARE DIRECTIVE

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive in West Virginia
After printing your document, you will need to finalize it. Below are the steps:

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses and a notary
3. Have witnesses sign and date
4. Have notary sign and date
5. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive. Review your state's laws on witness requirements for health care directives.

LIVING WILL

FOR

FirstName LastName

This document includes the following:

Medical power of attorney designating a health care agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.

Living will with health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

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

MEDICAL POWER OF ATTORNEY REPRESENTATIVE

The Person I Want to Make Health Care Decisions for Me When I Can't Make Them for Myself

Date: _____

I, FirstName LastName, hereby 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 unable to do so myself.

The person I choose as my representative is:

Name:	FirstName LastName
Relationship:	Spouse
Address:	111 Street Address
	City, West Virginia 11111
Phone:	1111111111
Email:	emailaddress@email.com

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

Name:	FirstName LastName
Relationship:	Son
Address:	222 Street Address
	City, West Virginia 11111
Phone:	1111111111
Email:	emailaddress@email.com

AUTHORITY OF MEDICAL POWER OF ATTORNEY 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, subject to any special directives or limitations stated below.

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, subject to the special directives and limitations as stated below: I do not have special directives and limitations at this time.

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.

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

LIVING WILL

The Kind of Medical Treatment I Want and Don't Want If I Have a Terminal Condition

Living Will Made _____ this day of _____(month, year).

I, FirstName LastName, 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 unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition, I direct that life-prolonging intervention that would serve solely to prolong the dying process be withheld or withdrawn. I understand that this would also mean the removal of any medically administered food and fluids, such as might be provided intravenously or by feeding tube. 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. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

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 give the following SPECIAL DIRECTIVES OR LIMITATIONS (comments about funeral arrangements, autopsy, mental health treatment, 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):

I do not wish to give special directives or limitations at this time.

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.

SIGNATURES

THIS DOCUMENT SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD, OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL

CARE.

FirstName LastName
Name of the Principal

_____ _____
Signature of the Principal Date

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.

_____
Printed Name of Witness

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

_____ _____
Signature of 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 dated 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