West Virginia Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will
[ ] Selection of Health Care Agent (Medical Power of Attorney)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will

I, 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 (1) physician who has personally examined me to have a terminal condition or to be in a persistent vegetative state (that is, if 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that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn.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, cardiopulmonary resuscitation, and dialysis 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 to accept the consequences resulting from such refusal. I understand the full import of this living will.

Selection of Health Care Agent (Medical Power of Attorney)

I, hereby appoint _____ (name), of _____ (address), 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.

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent

_____ (name of individual you choose as first alternate agent)
_____ (address)

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, 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, and dialysis may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments):**

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

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**
[ ] eyes [ ] bone and connective tissue [ ] skin
[ ] heart [ ] kidney(s) [ ] liver
[ ] lung(s) [ ] pancreas [ ] other _____
for the purposes of:
[ ] any purpose authorized by law **OR**
[ ] transplantation [ ] research [ ] therapy
[ ] medical education [ ] other limitations _____

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will
[ ] Selection of Health Care Agent (Medical Power of Attorney)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____

On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent and Attorney-in-Fact for Health Care

Signature _____ Date _____