STATE OF WEST VIRGINIA
MEDICAL POWER OF ATTORNEY

Dated:_____, 19_____

I,_____, hereby appoint
(Insert your name and address)

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

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. If my representative is unable, unwilling or disqualified to serve, then I appoint _____
(Insert the name, address, area code and

_____ as my successor representative.
telephone number of the person you wish to designate as your representative)

This appointment shall extend to (but not be limited to) 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 act on my behalf to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, 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, the withholding or withdrawal of life-prolonging intervention when in the opinion of two physicians who have examined me, one of whom is my attending physician, such life-prolonging intervention offers no medical hope of benefit.

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 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 health care provider, or administrative or judicial agency.

It is my intent that this document be legally binding and effective. In the event that the law does not recognize this document as legally binding and effective, it is my intent 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.

SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (If none, write "none".)

_____

_____

_____

_____

--Over--

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

These directives shall supersede any directives made in any previously executed document concerning my health 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 according to the laws of intestate succession of the state of the principal's domicile 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 _____, to-wit:

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 _____, 19____, have this day acknowledged the same before me.

Given under my hand this _____day of _____, 19 _____.

My commission expires:_____

_____
Notary Public

STATE OF WEST VIRGINIA
LIVING WILL

Living will made this_____ day of_____(month, year).

I, _____, being of sound mind, willfully and voluntarily declare that in the absence of my ability to give directions regarding the use of life-prolonging intervention, it is my desire that my dying shall not be artificially prolonged under the following circumstances:

If at any time I should be certified by two physicians who have personally examined me, one of whom is my attending physician, to have a terminal condition or to be in a persistent vegetative state, I direct that life-prolonging intervention that would serve solely to artificially prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any other medical procedure deemed necessary to keep me comfortable and alleviate pain.

SPECIAL DIRECTIVES OR LIMITATIONS ON THIS DECLARATION: (If none, write "none".)

_____

_____

_____

_____

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.

Signed_____

Address_____

_____

(Over)

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

Witness_____

Address_____

_____

Witness_____

Address_____

_____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me this _____

_____ (date) by the declarant and by the two witnesses whose signatures appear above.

My commission expires:_____

_____

Signature of Notary Public

Wallet Cards for Advance Directives

Cut out and complete the cards below. Put one card in the wallet or purse you carry most often, along with your driver's license or health insurance card. Keep the second card on your refrigerator, in your motor vehicle glove compartment, a spare wallet or purse, or other easy-to-find place.

ATTENTION HEALTH CARE PROVIDERS

I have created the following Advance Directive:
(Check one or both, as appropriate)

_____ Medical Power of Attorney
_____ Living Will

Please contact _____
(Name)

_____
(Address)

_____ for more information.
(Telephone)

_____ _____
Date Signature

ATTENTION HEALTH CARE PROVIDERS

I have created the following Advance Directive:
(Check one or both, as appropriate)

_____ Medical Power of Attorney
_____ Living Will

Please contact _____
(Name)

_____
(Address)

_____ for more information.
(Telephone)

_____ _____
Date Signature