STATE OF WEST VIRGINIA
MEDICAL POWER OF ATTORNEY

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

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 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.

_____

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 WEST VIRGINIA

COUNTY OF _____, To-wit:

The foregoing instrument was acknowledged before me this ____ day of _____, 20____, by _____ and by _____ and _____ _____ , the two witnesses whose signatures appear above.

My commission expires _____.

_____
Notary Public