

COMBINED MEDICAL POWER OF ATTORNEY AND LIVING WILL

Dated: _____, 20____.

I, _____, residing in _____, West Virginia, being of sound mind and desiring to make advance arrangements for the handling of my personal affairs by appointing a representative for health care decisions and by declaring my intentions regarding the use of life-prolonging medical intervention, hereby undertake and declare the following:

FIRST, I 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 not able to do so myself (hereinafter referred to as my “representative”). If my representative is unable, unwilling, or disqualified to serve, then I appoint _____, as my successor 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 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, the withholding or withdrawal of life-prolonging intervention.

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 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 follows:

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

SECOND, I hereby execute this Living Will and declare that I want my intentions to be respected by my representative, my family, and all health care providers if I am sick and not able to communicate my intentions 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 sick and not able to communicate my intentions 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 surroundings nor able to interact with others), I direct that life-prolonging medical intervention that would serve solely to prolong artificially 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 effectively to alleviate my pain.

I give the following SPECIAL DIRECTIVES OR LIMITATIONS:

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 I accept the consequences resulting from such refusal. I understand the full import of this document.

IN WITNESS THEREOF, I have affixed my signature and seal as of the day and year first above written.

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: _____

Witness: _____

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